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FIG 1

TO ILLUSTRATE DR ALLAN JAMIESON'S CASE OF MYCOBIS FUNGOIDES BEFORE
TREATMENT JULY 2, 1892.

FIG. 2

TO ILLUSTRATE DR. ALLAN JAMIESON'S CASE OF MYCOSIS FUNGOIDES AFTER
TREATMENT BY X-RAYS. OCTOBER 17, 1902

ERRATUM—JANUARY NUMBER.

Dr. ALLAN JAMIESON's Case of Mycosis Fungoides, Fig. 1.
For July 2, 1892, read July 2, 1902.

THE BRITISH JOURNAL OF DERMATOLOGY.

JANUARY, 1903.

MYCOSIS FUNGOIDES, AND ITS TREATMENT BY THE X-RAYS.*

By W. ALLAN JAMIESON, M.D., F.R.C.P.E.,

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Diseases of the Skin, Royal Infirmary, Edinburgh.*

TEN years ago I had the honour to read before this Society a paper on "Mycosis Fungoides," and as two examples of that comparatively rare disease have been recently under my care at the Royal Infirmary, I desire to bring these under its notice. One, because it exhibits an unusual phase; the other, as quite remarkable results have followed somewhat prolonged exposure to the X-rays. During these years, though many cases have been investigated and recorded, little, if any, further light has been thrown on its pathogeny. The more delicate methods of staining the tissues now in vogue have indeed enabled the various cell-structures to be more accurately differentiated, but observers are not in agreement as to the source whence the more characteristic of these are derived, no causal microbe has been discovered, and its origin remains as obscure as it was in 1892.

A. J., 66, engineer, Carron. Admitted to Ward 37, 27th May, 1901. Notes taken by Dr. Grey Brown, Resident Physician. A strongly-built man who had had good health, though he admits having

* Read before the Medico-Chirurgical Society of Edinburgh, on 5th November, 1902.

had a sore on the penis more than forty-three years since, concerning which he can give little information, though he says he has had no trouble as to that since. There are, however, on the inner side of the knees several small scars, rather larger than a pea, white, with a ring of pigment round each, which resemble those left by a syphilitic ulcer.

He dates his present illness from three years ago, when after being over-heated some little "pimples" appeared on both wrists and later on the legs, particularly on the shins. These again disappeared later. About a year ago the face became affected, the bridge of the nose being the starting point. The condition on the face was a dry, scaly, itchy one, spreading from the bridge of the nose up over the forehead and down the cheeks. Before the complaint began he had a good crop of hair, but this fell out over a great part of the front of the right side of the scalp, and in a circular area on the crown. The affected parts gradually became red and weeping, as at present. On the right leg below the knee several raised areas showed themselves a year since, and also others nearer the patella, three months since. On the inner side of both thighs are reddened, crusted, ill-defined areas, much like crusted eczema, which showed themselves three months ago. All these itched to a considerable extent, but the pruritus is now replaced by a burning sensation if anything more than discomfort is complained of.

The greater portion of the face, extending well over the forehead, and including the ears, presents a yellowish-red, swollen, granular oedematous, oozing surface. The skin feels thickened and velvety. Only those portions of the face and scalp which are hairless, either naturally or from denudation, are affected. The bald portion on the crown is dry though the skin is thickened, but it has a curious pitted appearance, imparting a worm-eaten aspect to the surface. As a contrast to this there are scar-like areas in bands about an inch broad, sharply defined from the granular parts, on the left side of the forehead and left cheek. These are smooth, pale and hairless; he states that these were at one time moist and swollen like the other parts, but healed. On the nape of the neck are dry purplish-red, rough thickened patches. Under the knee on the right side are several moist, red, granular, weeping patches, like those on the face. On the inner side of both thighs is a wide, dry, crusted area, including scar-

like parts, which he says were originally moist. The urine was examined shortly after admission. It was clear, straw-coloured, reaction acid, sp. gr. 1·020. No albumin, sugar, or phosphates. Dr. Gulland examined the blood, which he found to contain a slight degree of increase of white corpuscles, and a very moderate degree of eosinophilia.

To cleanse the parts boric starch poultices were applied, and under them the œdema somewhat subsided, so that he could open his eyes more easily, but the discharge assumed a muco-purulent aspect, instead of a straw-like serous oozing, in places, too, tinged a little with blood. His appetite was good, his temperature and pulse normal till the morning of the 3rd June, when it rose to 98·8° and in the evening to 100·4°, and the pulse to 84. On the morning of the 4th, temp. 99·6°, pulse, 82. Even., temp. 102°, pulse 108. On the 5th, temp. 100·2°, pulse 84. Various patients had a rise of temperature on these days, and in his case the bowels was confined, though a laxative and milk diet did not wholly reduce it. He was placed on the 4th on iodide of potassium thrice a day, ten grains, with carbonate of ammonia.

A section of the mucous-like growths on the leg, which had exactly the same structure as that on the scalp, was prepared by Dr. Welsh, and stained with various reagents. The horny layer was defective, the keratohyalin had disappeared, and there were no perfectly cornified cells present; the epithelium was ragged and the cells defective. Among the surface cells were numerous leucocytes making their way outwards. The rete showed elongated inter-papillary processes; the lengthy and œdematous papillæ contained dilated blood-vessels, well filled with blood. The cells of the prickle layer exhibited a well-marked fibrous structure, the uniting mesh-work between individual cells being fairly distinct. Below this there was a granulomatous condition, cells with a slightly granular protoplasm, containing large nuclei, which stained well, some round, some oval, embedded in a structureless stroma. The deeper part of the corium and subcutaneous tissue, so far as visible, was apparently normal.

June 25th.—Various dressings were tried, including ung. vaselini plumb., but all caused an increase in the purulent discharge and arrested cicatrisation; the poultices were therefore resumed, but charcoal and linseed were used in place of starch, as the odour was

foetid. These did well, and under them much fresh scar tissue formed, so that now there are only small areas still moist and raw. The iodide was discontinued on the 15th, and an acid mixture with quinine and strychnia substituted, and since then his appetite has somewhat improved. But the temperature rises every night, to fall from two to three degrees each morning. On the 16th it read 104.2° , and last night it was 101° . He has wasted much too, and for the last two days there has been incontinence of urine, and he has rambled at times. An abscess formed at the back of the right thigh, discharges copiously, and shows no sign of closing. Dr. Gulland again kindly examined the blood, and reports: "It shows a marked leucocytosis, over 90 per cent. of polymorphs. The eosinophiles have quite disappeared, and the blood now simply reflects some septic or inflammatory condition."

July 15th.—He has wasted very considerably, has a troublesome cough, with a good deal of muco-purulent expectoration. The abscess shows no sign of healing, and another brawny mass has formed close to the anus, which on being opened by Mr. Hodsdon disclosed rather a carbuncular condition than an abscess cavity. It too is sloughing. The face is now nearly all cicatrised, though as the surface is still tender pieces of salve muslin are applied here and there. The temperature at night reaches about 103° , but drops several degrees in the morning. The pulse is flabby, and somewhere about 80° . He eats fairly well but does not nourish, and he speaks feebly. There are no bedsores.

July 18th.—The temperature has been steadily falling, though not yet quite normal at night, and the carbuncular mass is cleaning, and Mr. Hodsdon says doing well. But the cicatrix on the whole of the right side of the face has again broken down, so that the surface is granular, eroded, and excreting serum. In fact, it has returned to the state it was on admission. The left side is still cicatrised.

He remained in much the same state during the three months following, at times improving a little, the surfaces showing symptoms of cicatrisation, then rapidly and unaccountably breaking down. The abscesses never closed completely, while mentally he became more obtuse. On October 18th he was admitted into the Longmore Hospital, but three days later he had to be transferred to the lunatic asylum at Larbert, where he died very shortly after.

(2) Mrs. G., 54, was sent to me by Dr. Simpson, of Golspie, Sutherlandshire, on the 24th June, 1902. She seemed, apart from her cutaneous affection, in fairly good health. Her appetite was good, tongue clean, bowels regular and urine normal. She has three children, 18, 14, and 10 years old, and in excellent health, as is her husband. There is no instance that she knows of of skin-disease in the family or near relations, nor is she aware of anyone in her neighbourhood similarly affected as herself. She has, however, rather a tender skin.

Ten years since an irritable red spot the size of a shilling showed itself on her neck, below and behind the right ear. The opinion of a doctor from London, who happened to be in Golspie, was asked with regard to it, but no treatment was ordered. Zinc ointment, however, appears to have been applied, and for two or three years no others came, then a few manifested themselves. These were very itchy and always dry. On June 2nd, 1900, she consulted me with regard to them at the Royal Infirmary. There were then a series of red, dry, slightly-raised and scaly, itchy patches on the right side of the lower part of the neck and face, but no tumours; these first appeared in January, 1901. Within the last two years she has twice had erysipelas of the face.

There are now ten tumours pretty closely set on the side of the right jaw, varying from a pea to a walnut in size. Some of these are smooth and hemispherical, others are ruptured and crateriform, with a greyish slough in their centre. Their colour lies between a dark and a pale pinkish-red respectively. The epidermis over them, where preserved, is thin and smooth, and their consistence is firm and flesh-like, not hard. The intervening skin is in places white, as if cicatricial, in places pinkish-red, but she maintains that the white areas do not necessarily represent previous tumours which have become absorbed, and it is certain that a few have done so and have left no trace. All the front of the neck below this is of a pinkish-red colour, tense, and somewhat thickened. On the sternum is a raw oozing patch, like weeping eczema, but not elevated, within a reddened area. There are in front of the chest a number of round or oval, red, well-defined patches, with slight thickening of the skin, and an isolated, flattish oval tumour, the shape and size of a mussel-shell. On the forehead, within the hair margin, is a

faintish red macule, exhibiting the very earliest trace of the disease, and on the right breast are two rose-pink smooth macules, slightly later. There are some patches on the left side of the neck and below the left ear, also an ill-defined pinkish nodular patch on the tip of the right shoulder, and at the margin of the same axilla, an oval raised smooth patch, almost a tumour. Besides itchiness, the diseased parts when exposed to the air, and particularly to air in motion, are acutely painful.

On the 26th July her blood was examined by Dr. Lovell Gulland, who reported as follows :—" I counted Mrs. G.'s blood the other day. She has 6,250,000 red corpuscles with hæmoglobin to correspond, and 13,000 white corpuscles. The films show no abnormality except that the proportion of the polymorphonuclear leucocytes is rather increased—a slight leucocytosis. No eosinophilia. The high count of reds is probably due either to a general or local stasis of circulation. The blood was taken from the ear, and it is just possible that the condition of her neck may interfere slightly with venous return, or there may be a more general weakness of circulation."

Very soon after her arrival in Edinburgh she attended regularly as an out-patient, and treatment by the X-rays was commenced. The exposures lasted from three to five minutes to each part, a soft tube being employed at a distance of four inches, the interruptions being of medium rapidity. After each a little vaseline was smeared on. The itchiness and tenderness were considerably relieved by painting with calamine lotion made up with camphor water, which could be readily washed off before the exposure. The effect was a steady and continuous shrinkage in the tumours, but some fresh developments took place on parts not put under the influence of the rays. Thus in the beginning of September a new patch appeared within the hair margin on the left side over the temple, near where the earliest spot was visible on her admission. About the middle of the same month two other blotches came out, one on the corresponding portion of the right temple, the other at the back of the scalp. On the 16th September all these were raw, superficially oozing and crusted. Somewhat similar patches had also formed on the thorax, upper part of the abdomen, between and beneath the breasts, and on the nipples.

Up till the 18th October, when she left for home, where for

domestic reasons she was obliged to go, she had had exposures on sixty different days. For long before she went every diseased area was exposed in turn, so that she had as much as an hour and a quarter in all on each occasion. No reaction such as necessitated interruption of the treatment ever manifested itself. All the tumours had quite disappeared. On the right side of the face and neck the skin was now perfectly smooth, but there was some loss of substance, so that the region presented a somewhat puckered appearance. A faint redness remained within which still persisted the white spots which were there in June. There was no infiltration. The rest of the neck was smooth and soft, with a little mottled pigmentation, some leucodermic spots and a rosy pink macule or two. Only one of the patches on the scalp had not yielded to treatment, a small one on the left side, 3 inches above the ear. The nipples were almost normal. There was a small nodule the size of a pea in the bend of the right elbow, and behind the left knee, and at the outer side of the right, three patches in all, averaging the size of a florin, and slightly moist. Everywhere else the patches or thickening had wholly become absorbed, or had left only faint brownish staining. Only at the site of the few still oozing areas mentioned was there a little very bearable itching, elsewhere that and the tenderness or pain had entirely vanished. She expressed herself as feeling very well, while the improvement in the state of her skin had a most beneficial effect on her spirits.

On 21st November she wrote to me as follows: "All the parts which have been treated with the rays are entirely cured. My head is almost bare now, but perfectly free of the trouble, and is very nice and clean. There are a few irritable spots on the lower part of my back."

With the consent of the patient, portions of an early patch on the shoulder and of one of the tumours on the face were removed for examination. Dr. Shennan, the Pathologist to the Royal Infirmary, as also the Assistant Pathologists, Dr. Macdonald and Dr. Beattie, took a great interest in investigating the microscopic appearances, and Dr. Shennan has kindly furnished me with the following report:—

"1. *Early Patch*.—The epithelium is thin, and the stratum corneum tending to separate. The nuclei stain well, and from the

under surface columns of cells project downwards into the corium. The outline of these is not so defined as normal, and in them occasionally a small epidermic pearl is seen.

“In the papillæ of the corium, which, as a rule, are flattened, there are collections of cells arranged round about the small blood-vessels. These vary greatly in size. Similar collections are present deeper, round the vessels, but also in relation to the hair-follicles and sebaceous glands, and even in the sweat-glands the cellular elements appear to be increased round the acini. The clusters increase in size in the deeper parts, but all have essentially the same structure.

“The vessels invariably have thickened walls. This appears in most cases due to proliferation of the endothelium, by which in some cases a layer of large oval cells, one or two deep, encircle a small lumen. The muscular coat is not easily distinguished, being represented at the most by a few cells. Inside the endothelium, in some vessels, the lumen is lined by a thin homogeneous layer, the nature of which is difficult to make out.

“Spaces, rounded or elongated, occur in the cellular mass containing similar large cells, probably lymphatic spaces.

“In addition to these cells, others, smaller and taking a deeper nuclear stain, are evident in the reticulum of the nodule. These are young connective-tissue cells and lymphocytes. A few multinuclear leucocytes are occasionally seen in the nodule, in the vessel or in its wall. Mast-cells, presenting a dark brown granular staining, and plasma-cells, showing a small nucleus with clear space round it and beyond this protoplasm coloured blue, are encountered here and there. The endothelial cells are frequently degenerating, and contain small particles of granular dark pigment.

“2. *Tumour*.—Here the tissue is very cellular, but there are numerous blood-vessels, some with thin walls, embryonic; most corresponding to those described in the early condition. There are numerous endothelial cells, with large oval nuclei, connective-tissue cells, and lymphocytes. Few leucocytes are met with. There are cells corresponding, after staining with polychrome methylene blue, to Unna's plasma-cells and a few mast-cells.

“There are areas of necrosis, in which small blocked vessels can be made out, this evidently determining the necrotic change. In the

walls of some of the vessels and in the reticulum a hyaline transformation is seen."

Certain differences in the clinical aspect of these cases are observable. In the first the early symptoms were those of a dry and scaly, subsequently of a moist and crusted eczema, but the sequences were wholly at variance with what we are accustomed to see in eczema. The skin in various parts broke down into ulcers, which never healed soundly, while in places deep abscesses arose. There were no tumours strictly speaking, yet the microscopical appearances and the mode in which it terminated fatally were quite compatible with the diagnosis of mycosis fungoides. The loss of hair in course of the advance of the disease has been encountered in other instances, and has led to a comparison with leprosy. There was no reason to believe that the syphilis from which he had suffered long before had any relation to his ailment, and treatment on that supposition was rather detrimental than otherwise. It resembled most closely that contributed to Galloway and MacLeod's article* by Stephen Mackenzie, where "the disease seemed to be restricted to the types showing erythrodermia, diffuse superficial infiltration, followed by extensive ulceration of the surface, without the tendency to the production of massive granulomatous infiltrations or tumours."

The second, however, exhibited features quite unmistakably those of classical mycosis fungoides. The prolonged prodromal period, with the dry, circumscribed, intensely pruriginous areas, and the eventual development of characteristic tumours, rendered identification unequivocal. Though sections from the thickened patches and from the tumours did not in every respect correspond to what has been described in some other cases, yet these showed a complete general resemblance to what has been found as a rule. Indeed, the variations in histological findings constitute the grounds on which divergent ideas have been based as to the nature of the disease, some classing it with sarcoma, others, especially French authors, with lymphadenoma, and a third maintaining that it should be included in the group of the infectious granulomata, which, on the whole, seems the most probable hypothesis.

The special interest which the case possesses relates to the results of treatment. Hitherto nothing has served to stay its deadly pro-

* *Brit. Journ. of Derm.*, May, 1900, p. 160.

gress. One instance has been reported as having recovered after an attack of erysipelas, but in Mrs. G.'s case, though the wave of erysipelas twice passed over her face after the establishment of the tumour stage, no amelioration, far less any temporary arrest, ensued. But the effect of repeated exposures to the X-rays was immediate and satisfactory. Not only did the tumours melt wholly away, but the thickened patches likewise disappeared, and as they became effaced the itchiness ceased to assert itself, showing that the rays have a distinctly inhibitory power on the as yet unknown exciting cause. Still, though the rays could cure existing lesions, they could not entirely prevent new ones from cropping up, chiefly, however, on the scalp, where the hair masked the earliest traces. What has been accomplished in the way of cure of the fully-established disease warrants the hope that, attacked betimes, still better results will be obtained, and therefore in future no effort must be spared to discriminate the condition in its inception. While we were unprovided with a cure it did not, perhaps, matter so much whether the symptoms in an individual instance pointed rather to a possible mycosis fungoides than to an obstinate eczema, but now any circumscribed, very itchy and rebellious eczematoid eruption is to be regarded with suspicion, and ought to be subjected, if at all possible, to the rays. I cannot close this record without expressing my thanks to Dr. Norman Walker and to Dr. Frederick Gardiner, my House Physician, for the care and trouble they took to carry out the treatment during my absence from town.

PROFESSOR v. DÜRING-PASCHA'S REPORT ON ENDEMIC
AND HEREDITARY SYPHILIS IN ASIA MINOR.*

A REVIEW WITH REMARKS.

By GEORGE OGILVIE, B.Sc., M.B. EDIN., M.R.C.P. LOND.,

*Physician to the French Hospital and to the Hospital for Epilepsy and
Paralysis, London.*

DR. E. VON DÜRING-PASCHA, Professor of Dermatology and Syphilis at the Imperial Medical College of Constantinople and senior physician to the Hospital in Haidar-Pascha, best known to dermatologists by his Clinical Lectures on Syphilis (1895), has spent the last two years, 1899-1901, in the Vilajet of Castamuni (Asia-Minor), where for more than forty years syphilis has been raging to such an extent among the Osmanlie population that whole villages have been laid waste by the endemic disease. Such a state of health was sure sooner or later to forcibly react on the military competency of the province. The constant diminution of the number of those fit for army-service made itself all the more felt because it is from these districts that the regiments for the metropolis are chiefly recruited. Several attempts to grapple with the calamity had proved complete failures because the measures employed were far from sufficient and the individuals trusted with their execution not to be depended upon. In 1896 Professor v. Düring was commissioned by the Turkish Minister of War to report on the spread of syphilis throughout the province and to submit to the Government suggestions for combating the disease. After a few months he returned, but had to wait for three years until his proposals were adopted and then not without the personal interference of his Majesty the Sultan, who is keenly

* "Briefe aus Kleinasien" (Letters from Asia Minor), by Professor E. v. Düring in Konstantinopel. *Deutsch. Med. Wochenschrift*, 1902, Nos. 12, 18 and 28. "Studien über endemische und hereditäre Syphilis," by Professor Dr. E. v. Düring-Pascha. *Arch. für Dermatologie u. Syph.*, Bd. 61. Sonderabdruck, Wien., 1902, p. 74.

interested in hygienic matters. For well-weighed reasons v. Düring took care to have the execution of his scheme entrusted to himself. Under exceptional difficulties, which are vividly narrated in his interesting letters, he has achieved a task of which he may justly be proud.

The province covers an area of 6,000 q. km. and has about one million inhabitants. Specific treatment was practically unknown, the disease was either left to itself, or to "empirics"—frequently worse than the disease. During these two years ten hospitals were built and completely fitted up according to the requirements of modern medical and sanitary science. They contain altogether 730 beds for syphilitic patients. Two more hospitals are in the course of erection. Seventeen out-patient departments are distributed all over the province, where patients are seen every day. An effective medical and sanitary service has been organised and the co-operation of officials, police, even of the priests, has been secured for carrying out the hygienic measures ordained by law. Of course, time is as yet too short to expect tangible results with regard to an improvement in the general state of health of the province. Suffice it to say that during the seven months between March and October of last year 7,288 people suffering from syphilis have been under treatment in these institutions, of whom 2,689 have been received into the wards. To all who know the beneficial effect of specific treatment, of sanitary improvements, of preventive measures on the course of syphilis, these numbers speak for themselves.

Professor v. Düring's paper is based on the examination of about 65,000 people in the province of Castamuni, and altogether on more than 80,000 cases of syphilis. He aptly compares the impressions received on his expedition—travelling from one place to another, rarely seeing a patient more than once, but not unfrequently examining the whole populace of a village, or a small market-town at a time—to instantaneous photographs. This mode of observation has certain advantages which even a long hospital experience or an extensive private practice cannot afford. In his case it has not been without considerable influence towards changing his views with regard to several fundamental points in the nosology of syphilis.*

* Compare the same author's art. "Lues Hereditaria" in *Bibliothek der medicin. Wissenschaften*. Bd. X., 1900.

“ Without losing sight of general questions or single interesting cases, every district has been examined with regard to certain definitely formulated questions. The examination of, say, 10,000 people, amongst whom 1 to 3,000 are syphilitic, with regard to the number of births, to the existence of signs of degeneration, or to questions of heredity in a narrower sense, &c., is bound to give weightier results than if one is intent on noticing every detail in these gigantic numbers.” Of course sufficient matter has been collected to fill a number of monographs on important and unsettled questions. The author expresses his hope that one or the other of these will in time receive the separate and thorough treatment which they deserve, while at the same time he despairs of doing justice to all of them. Meanwhile he lays before the profession the general results he has come to without statistical apparatus, without single histories of typical or exceptional cases. Extent and mode of observation, the rareness of an opportunity to watch now-a-days the natural course of syphilis through several generations uninfluenced by treatment, not least the distinguished scientific position of the author, render his communication one of exceptional interest and importance. As the title indicates, the paper is divided into two parts. I shall limit myself to those of the author's statements which are either new or in opposition to current opinions, at the same time urging the reader to repair for fuller information to the fountain-head, for, as Bacon says: “ Distilled books are like common distilled waters, flashy things.”

Endemic Syphilis.—The prominent and characteristic features of endemic compared to sporadic syphilis are the preponderance of accidental over venereal infection and the frequency of tertiaries. While in Europe the *proportion of accidental to venereal infection* is at the utmost 5 in 100, the inverse proportion will come nearer the truth in Asia Minor, although v. Düring is unable to give even approximately exact numbers. To see a chancre is extremely rare (not 4 in 1,000). Even with the help of a scar the seat of the primary lesion could only be made out in less than a hundred cases. In the overwhelming majority of these it was to be found between the navel and the symphysis pubis, and due to homosexual intercourse. The other principal vehicles of infection are drinking vessels, the “nargile,” or waterpipe, the razor, and the cigarette, which is considered

and used as common property. In spite of the great frequency of acquired syphilis in children, v. Düring has never been able to detect the primary lesion in an infant or child. In all reports on endemic syphilis the *proportion of tertiaries to secondaries* is given as about 2 to 1. This, according to v. Düring's experience, is wrong. In computing the relative frequency several circumstances have to be taken into account which have been neglected by former observers :

- (1) The peasants, as a rule, do not seek medical advice for secondaries, because they do not attach any importance to them.
- (2) All people escape registration during the periods of latency.
- (3) Without treatment tertiaries persist about twelve times as long as secondaries ; consequently the same individual will figure in these statistics for years.
- (4) In an "extinct focus," i.e., where in the course of years all inhabitants are infected—a by no means rare occurrence—only cured people, or those suffering from tertiaries, are to be found. The examination of the whole populace of large districts, as practised by v. Düring, gives more trustworthy results. In this way v. Düring has found the proportion of tertiaries to secondaries is 1 to 1·2. For some of the reasons given above this has to be further restricted. According to v. Düring's opinion 1 to 2 will be about the correct estimation of the relative frequency between tertiaries and secondaries. Reliable statistics with regard to the frequency of tertiaries in Europe do not exist. The average generally accepted is 1 to 10. It is therefore evident that tertiarism, although not nearly as common as previously reported, is yet exceedingly frequent in endemic syphilis. What is the reason for this increased frequency ? The opinion that syphilis is attenuated by running through several generations was still held by the author at the time of his first report to the Government on the causes of the preponderance of tertiaries (1896), but has been abandoned by him altogether, in consequence of his researches during the last two years. The alleged attenuation of syphilis in Portugal is a myth.* Endemic syphilis does not, as a rule, present the features of malignant syphilis, properly understood. Of true malignant syphilis the author has not seen more than six cases, of which four died. Precocity and frequency of tertiaries do not constitute the character

* *Vide* my paper "Syphilis among British Troops, Portugal, 1812—India, 1896." This Journal, 1898, July.

of malignant syphilis. The precocity, frequency, extension, gravity, and long duration of tertiaries in endemic syphilis are really due to the *want of treatment*. Near cities, or in cities, syphilis follows nearly the same course as with us; the further removed and the more secluded the villages, the greater the frequency of tertiaries. Insufficient nutrition, poverty, malaria, tuberculosis, etc., are important co-operative factors.

Destructive processes of the palate, the pharynx and the nose constitute about 40 per cent. of all tertiaries; the tongue is frequently affected (in about 6 per cent. of the cases). There exists an excessive vulnerability of the mucous membranes of mouth and pharynx, which also manifests itself in an increased sensitiveness to the effects of mercury, particularly when given internally. This, the author suggests, may be the consequence of the wretched quality of their bread. Leukoplasia of the mouth is frequently seen even outside the domain of syphilis, but even if of syphilitic origin it is not influenced by specific treatment; it seems to be the only "parasyphilitic" lesion allowed by the author. Diseases of the eye and their sequelæ are remarkably rare, also affections of the nervous system. This may be explained by the connection between the localisation of syphilis and "irritation" or use. Alcohol is unknown. Syphilitic functional disorders, such as neurasthenia, melancholy, etc., v. Düring does not admit. Tabes he has seen three times among the populace of towns, never in the country. Only in one case was there a previous history of syphilis. v. Düring is a decided opponent of the doctrine of the syphilitic origin of tabes and of "parasyphilis." The "chronic-intermittent" treatment by mercury as practised by Fournier he *denounces as dangerous*; he does not hesitate to make it responsible for the frequency of nervous disorders in the statistics published from Fournier's school.

Hereditary Syphilis.—The author begins by some remarks in defence of his and Finger's toxine-theory of tertiarism and immunity. This theory from the first has been unacceptable to me, and I am therefore glad to find that v. Düring now attaches very little weight to this or any other theory of syphilitic heredity which is modelled on the pattern of some other infectious disease. Every such theory is of necessity a Procrustean bed, into which clinical experience cannot be wedged without much wrenching or stretching of facts. We

have had enough and to spare of ingenious speculations to explain the "laws" of syphilitic inheritance, but the more conscientiously we scrutinise the clinical evidence, the more do these so-called laws turn out to be little more than rash and premature generalisations. The time for a uniform theory of syphilitic heredity has not yet come, and I have to confess that all the "airy subtleties" which in the disguise of scientific pathology have caused so much throwing about of brains have—to use Sir Thomas Browne's anatomical language—"never stretched the *pia mater* of mine." That the toxine-theory of tertiarism is in direct opposition to certain clinical facts, v. Düring now frankly admits. Some of the arguments advanced against it by Hochsinger seem to me irrefutable.

Conceptional syphilis, tertiarism *d'emblée*, Syphilis hereditaria tarda, i.e., without infantile symptoms, are, according to the author, well demonstrated facts. He grants that every individual case must remain open to doubt, yet clinical experience taken in its totality, in particular that gained from private practice, decides in favour of these occurrences which only *undue scepticism* can call in question.

"Profeta's Law" is discussed at some length. Extensive examination of children the offspring of syphilitic parents has led v. Düring to the conviction that "the value and consequence" of this "law" is "*equal to nil*." He has collected *more than one hundred* cases in which the children of parents who before marriage unquestionably suffered from acquired syphilis, contracted fresh syphilis. Therefore Profeta's law—in its enlarged, as well as in its original restricted meaning—"shrinks into naught."* I want to lay particular stress upon the fact that v. Düring has never seen the case of a mother with infectious lesions on the breast suckling her healthy child, which alone could afford an opportunity to test the child's immunity. Mr. J. Hutchinson† likewise declares that his "own memory supplies but one example in which he actually witnessed the secondary stage a pregnant woman and the child was born and remained healthy."

In this case it is not even stated whether the mother had secondaries on her breast and whether she suckled the child. Consequently the

* See my paper, "Congenital Immunity to Syphilis and the So-called 'Law of Profeta.'" This Journal, 1899, February and March.

† "Twentieth Century Practice of Modern Medical Science," edited by Th. L. Adamson, Vol. XVIII., Art. "Inherited Syphilis," London, 1899, p. 396.

case is not one "especially fulfilling these conditions." In fact, Mr. Hutchinson's declaration amounts to a round confession that he does not remember a single case which could be adduced in favour of Profeta's statement. He all the same lends his authority to support the "law." This, of course, is a question of personal creed not subject to scientific discussion. Syphilography presents many strange instances of "over-legislation," but perhaps there never has been a "law" enacted on more flimsy pretences. The evidence on which it rests, "*è tanto, che non basta a dicer poco.*" Moreover, its denomination is faulty, because the same statement had been made previously and in a more precise form by E. J. Behrend.

Like Colles, Behrend speaks of immunity only for the time during which, between mother and child, there exists the relationship of wet-nurse, a usually well-defined period. Profeta, however, for reasons best known to himself, proclaims that the child born healthy of a syphilitic mother cannot contract syphilis until "rather late, when with the growing of the body, the organism is renovated" (*assai tardi quando cioè col crescere del corpo l'organismo si è rinnovato*). It is impossible to say to which stage of evolution this vague statement refers—perhaps to the time of puberty. For scientific exactness it is on a par with that made by Malvolio with regard to one "between boy and man," that "one would thinke his mother's milke were scarce out of him." What now goes by the name of the "law of Profeta," should properly be called Behrend's hypothesis. Mambrino's helmet has turned out to be nothing more than a shaving-basin, somewhat severely damaged. Historical as well as worldly justice demands either restoration to the legitimate owner or compensation. As the barber received his eight reals, thus Behrend should receive in text-books on syphilis the honourable mention he really deserves, but unless more substantial evidence is forthcoming in its favour, his suggestion must remain of doubtful value. There is no more a "law" of Profeta or Behrend, than there is a helmet of Mambrino.

Twice v. Düring has met with fresh acquired syphilis in children the subjects of inherited syphilis. With regard to the infectiousness of congenital syphilis, he expresses himself with great reserve. He does not deny it, but he states that if he had never seen an exception to Colles' law, he likewise has never seen a healthy nurse infected by

a congenitally syphilitic child, although he knows of several cases in which apparently healthy women have suckled children—not their own—affected with severe congenital syphilis. Mr. Coutts' important report from Shadwell Hospital is referred to, but v. Düring omits to mention that the only four cases of infection through congenital syphilis which this author was able to collect were all exceptions to Colles' law. He remarks that popular belief is not in favour of infection by suckling. Taking it "all in all," v. Düring comes to the conclusion that the dangers of infection by congenital syphilis as depicted by French authors must be considerably exaggerated.

Special attention has been paid by v. Düring to the dystrophic influence of syphilis, to its degenerating effect upon racial development. It is here that his observations, from the particular conditions under which they were made, are of greatest value. I am, therefore, glad to find that his recent experiences and the conclusions drawn from them are in perfect accord with the views which I have on different occasions expressed in this journal. The present tendency of the French school towards pansyphilism seems itself to be a kind of professional neurosis. One is certainly reminded of Mr. Lemuel Gulliver, surgeon, who, when reporting on his trip to Glubbudrib, indulges in "melancholy reflections" and observes how much the race of human kind was *degenerate* among us (viz., the British nation) *within these hundred years* past, how the *pox* under *all its consequences and denominations* had altered every lineament of an English countenance, shortened the size of bodies, unbraced the nerves, relaxed the sinews and muscles, introduced a shallow complexion, and rendered the flesh loose and rancid." This was written in 1727. It is the phantasmagoria of an embittered morbid mind, the "melancholy reflection" of a despondent sad man weighed down with the foreboding that he was to "die by top." Yet it reads very much like a passage occurring in a modern French address on "Parasyphilis" with its "stigmata dystrophiques," "infantilisme," "neurasthénie," "rabougrissement général," "un des facteurs les plus actifs et les plus rapides de la dégénérescence," "la grande corruptrice de la race humaine." Two centuries have elapsed since Dean Swift wrote the above, yet the English "now have thewes and limbs like to their
-----ors."

Of the extravagancies into which it leads I will give only one striking example, reported by a well-known physician, Dr. Barthélemy. He publishes the following story:—The father, *sixteen years before marriage*, contracts syphilis of a benign character, limiting itself to a primary lesion, roseola and some mucous patches. After three months' treatment he has remained well. He is of a vigorous constitution, likewise his wife, who is in perfect health. "Both parents are morally and physically irreproachable." The patient, the daughter, was born in the eighth month of pregnancy; at the time of examination, 21 years old, she presents a medley of anomalies: malformation and asymmetry of the thorax, asymmetry of the face, strabismus, slight prognathism, *tibias en lame de sabre*, all "sorts and conditions" of teeth, with the exception of Hutchinson's. No history of congenital syphilis. She is of average intelligence, her moral instincts are regular, but she has "kleptomaniacal impulsations." She has stolen several times "without necessity or malice, and is not conscious of the immorality of such acts." This poor creature "stigmatical in making, worse in mind," is seriously set up as a specimen of *moral parasymphilis*.* It is the third case of the kind which has come under the observation of Dr. Barthélemy, and he is led to think that "para-hérédosymphilis may lead to mental and moral perversions." I have no doubt that the number of such instances of moral hérédoparasymphilis will rapidly increase if he contents himself with establishing the connection between cause and effect with the same degree of logical cogency as he does in this case, with regard to paternal syphilis and theft. But I am speaking here not of an isolated case, but of a general principle. If everything from congenital cataract to club-foot, from a nævus to a supplementary cranial circulation, from hare-lip to an imperforated anus, from abortion to giantism, from a dermoid to pigment-anomalies round the optic disc, from strabismus to hæmophilia, from a dental erosion to spina bifida, from a third eyelid to cryptorchism, from absence of a tongue to three tongues, from prurigo to kleptomania, from stammering to incontinence of urine, from the "bad schoolboy" to complete absence of the brain, from a tooth-gap to moral gaps (*lacunes morales*), etc., etc., is to be suspected

* Fournier, Edm., "Stigmates dystrophiques de l'Hérédoparasymphilis," Paris, 1898, p. 261.

as a "stigma" of *parental* syphilis—"who should 'scape whipping?" By such methods the *historia morbi* is degraded to *anilis fabella*, casuistry to anecdotage, the science teratology to mere *reparéla*. I entirely agree with Professor v. Düring that these are "eccentricities which lead off the right path" and are "not void of comicality." He in particular refers to Dr. Ed. Fournier's book, "Stigmates dystrophiques, etc., 1898." No more befitting verdict could be pronounced on this profitless piece of painful plodding than in the words of Bacon, *nihil aliud est quam narratiunculorum et observationum futilium congregies quædam*. Like "breathless Phaeton" he mounted the paternal chariot—*currus auriga paterni*—and set out to "burn the world."

Finally, Professor v. Düring discusses the diagnostic value of the different symptoms of late hereditary syphilis. It is interesting to learn that affections of the joints, in particular of the knee-joint, occurred "with remarkable frequency" in his experience, while interstitial keratitis was "exceedingly rare." To my knowledge Clutton and Thomsom were the first in this country to draw attention to the connection between the two conditions, but with us the proportion is certainly the reverse. v. Düring describes a peculiar affection of the tongue as "superficial, interstitial, diffuse glossitis" which he has seen very frequently, and which, if combined with other changes," would warrant the diagnosis of congenital syphilis. According to his description there is no doubt that it is quite distinct from the "geographical" or "ring-worm" tongue which Parrot considered to be pathognomonic of the hereditary disease. v. Düring refers to a case published by me some years ago as the only one which seems to answer the picture drawn by him. Whether the two conditions are identical I am unable to say.

ACUTE SYMMETRICAL ERYTHEMATOUS KERATODERMIA, CAUSED BY THE ADMINISTRATION OF ARSENIC.

By R. PROSSER WHITE, M.D. ED., M.R.C.S. ENG.,

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THE following case of K. F. was admitted into the Royal Albert Edward Infirmary, Wigan, on June 8th, 1901, under Dr. Brady. He kindly transferred him to my care. For many of the following notes I am greatly obliged to Kenneth Fraser, M.B., the house-surgeon.

The boy, aged 13, was suffering from a severe attack of chorea, requiring his cot to be padded. He was treated with *Liquor arsenicalis* ms. 4 every four hours. The dose was increased until on the 17th he was taking ms. 10 every four hours. On the 18th he showed the physiological effects of the drug, irritation of the eyes, running at the nose, the silver-coated tongue, but no vomiting or diarrhoea. The administration of the drug was stopped. In the evening erythematous symmetrical patches, rose-pink in colour, appeared over all the metacarpo-phalangeal and phalangeal joints. Thenar and hyperthenar eminences appeared as light yellow, lemon-coloured islands, surrounded by erythematous rings. The markings of the palms of the hands and flexor aspects of the fingers were more noticeable, due to the rose-pink erythema extending along them. Erythematous zones also appeared on the flexure aspects of each wrist, and the extensor aspects of each elbow, and upon all points where pressure was brought to bear, as, for instance, over the spines of the scapulæ, the buttocks, the *raphé* between the buttocks, and the great trochanters of the femurs, especially the right. The bony prominences of the legs and feet were affected, the inner aspect of the left knee, the external and internal malleoli, and along the margin of the outer aspect of the feet, extending for half an inch or more along the plantar and dorsal surfaces. The soles of the feet, and the metatarso-phalangeal joints showed similar appearances to those of the hands.

All these zones were symmetrically circular, of a rose-pink colour, decided in the centre and fading away towards the margin, yet the margins themselves were well defined.

The zones were tender to the touch, and the skin was considerably thickened. There was a scarlet rash all over the body, simulating a fading or mild scarlet-fever rash. There was only slight œdema.

On the 20th all tenderness had gone, but the affected zones were still mapped out. These were now of a violet-brown colour, and the skin was still thickened. Towards the centre of these zones the epidermis was beginning to desquamate. The tongue had quite cleared up.

On the 26th, the zones appeared as brown, desquamating patches, the scales about the size of trout scales. At first the desquamation was confined to the centre of each zone. By July 3rd it had spread to the margin of the patches, where the epidermis peeled off in large white flakes. The mucous membrane of the lips was now seen to be desquamating. The *alæ nasi* were thickened and irritable.

Hairs taken from the head and scales from the desquamating patches were examined at the Thompson Yates Institute, Liverpool, but no trace of arsenic was found. The urine was examined from time to time for albumin and arsenic, with negative results.

The patient was discharged on July 21st, cured of the chorea, and without any trace of arsenical pigmentation. He received no arsenic after June 18th. During his stay in hospital $3\frac{1}{2}$ grains of arsenious anhydride were administered.

The appearance of this lad when the symptoms were most acute was very characteristic. His face was suffused with a general brilliant scarlatiniform blush, and the flush areas were marked out, as if the face had been dusted in patches with bright pink rouge. The skin over the joints where movement or friction occurred was much reddened, and the folds and creases were enlarged and deepened. On being stripped the same diffuse pink erythematous blush was found all over the body, which entirely disappeared with pressure, to reappear again upon its removal. Below the knees, when standing, and on the fore-arms, when dependent, the skin showed a mottled appearance, and the veins were more prominent than is usual in a boy of his age.

All over the skin the papillæ projected prominently, giving the familiar sensation of a "nutmeg grater" to the hand of the observer,

when drawn over the surface. This was particularly noticeable on the skin of the upper arms and outer aspects of the thighs.

The hyperkeratosis was especially distinct upon the sites where callosities usually form. The zones of highly coloured tint were evidently due to pressure or movement. Over the whole of the body there was a diffuse, branny desquamation, which appeared as the general redness subsided, and turned into a reddish brown or ham-tinted universal discolouration, leading to a small and varying amount of pigmentation.

This case appears to be especially interesting, if we may judge by the rarity and incompleteness of the usual descriptions given in text-books of acute dermatitis due to arsenic.

It shows the extraordinary selective activity arsenic exhibits in the skins of certain susceptible persons.

It illustrates the close resemblance (except in point of time) the acute symptoms bear to the skin-lesions found in chronic cases of arsenical poisoning.

It also points out the mode in which the injudicious giving of arsenic may aggravate acute skin-diseases, and proves its apparent specific action upon the nutrition of the skin, and the process of keratinisation.

We found that by stopping the drug all the symptoms decreased, which were again renewed when we readministered it.

That the vaso-motor action of the drug is a prominent factor in these cases is shown by the continual presence of slight œdema of the face, and on more than one occasion when the boy had been standing up for an unusual length of time, there was slight puffiness of the ankles and feet.

There was probably some slight inflammatory exudation, which caused the patchy, scaly dermatitis over the knuckles, the wrists, and points of the shoulders, etc. This was probably due to pressure and friction.

Besides the above case I have recently seen and had under my own observation others occurring in children presenting exactly similar appearances. These children had been taking large doses of arsenic, either by itself or in conjunction with other drugs.

I am therefore of opinion that such cases must be commoner than is generally believed by practitioners and hospital physicians. This

is probably accounted for by the fact that in the majority of cases where large doses of arsenic are given, the initial symptoms of poisoning are carefully looked for, and upon their first appearance the drug is immediately stopped.

The mucous membranes of the eye, nose, mouth, stomach and intestines, etc., are the first to show the effects of the drug, and these symptoms appear early; whereas the skin-affections seem to require a larger dose, or a longer continuance of it, to become developed.

In connection with the above cases, the points worthy of consideration are: (1) The possibility of some impurity in the arsenic administered tending to aggravate the symptoms? (2) Whether the combination of other drugs with the arsenic does predispose to this dermatitis? In one of the later cases, having stopped the arsenic and given small doses of potassium bromide, the child developed a discrete, sparsely distributed, apparently bromide rash.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

AN Ordinary Meeting of the above Society was held on Wednesday, December 10th, 1902, Dr. COLCOTT FOX in the Chair. The following cases and specimens were shown:—

Dr. GALLOWAY brought forward a patient—an Italian aged about 28 years—who presented an almost healed Herpes zoster affecting the tenth and eleventh dorsal areas. Scattered over his trunk, neck, and both upper and lower extremities were large numbers of small rounded superficial scars, arranged in herpetiform grouping. The groups of scars were surrounded by areas of much increased pigmentation. The patient stated that the scars resulted from a severe eruption which had commenced nine months before, and which had continued till about a month previous to the appearance of the present outbreak. The severe eruption had consisted of papules which became vesicular, and which was associated with much impairment of his health. Dr. Galloway remarked that there could be little doubt that the severe eruption leaving scars had been an

outbreak of *Dermatitis herpetiformis*. The interest of the case consisted in the fact that an attack of true *Herpes zoster* had occurred shortly after the disappearance of an eruption of *Dermatitis herpetiformis*, and had affected some of the areas previously attacked by the graver disease. The members present agreed with this diagnosis.

Dr. GRAHAM LITTLE showed a case of *linear Lichen planus* in a little girl, aged 4 years. The appearance when shown was as follows:—The affection seemed to commence on the upper and outer part of the right buttock, and in this position there was a band of small rather indefinite papules of a pale pink colour and slightly scaly. The band was about half an inch across, and descended vertically, becoming narrower as it reached the fold of the nates, and taking, just below the buttock, a sharp crescentic turn with the concavity outwards, as it spanned the space between the buttock and knee. At the latter level the line broadened out again, and became of a darker colour. In the upper and lower broader parts of the linear patch small papules of a fairly typical appearance could be distinguished. The history obtained was that the rash had commenced three weeks earlier as a small “pimply” (papular?) eruption on the thigh, and it was itchy from the first. There were no lesions elsewhere and the mucous membranes were free.

Dr. J. M. H. MACLEOD showed a case of superficial *Lupus vulgaris* of the type designated by Leloir as *Lupus érythématoïde*. The patient was a woman, aged 42 years, and the disease was restricted to the “bat’s wing area” of the face, the upper lip, and the mucous membrane of the nose. On the malar regions there were symmetrical patches made up of superficial soft nodules about half the size of a split-pea, which had coalesced, and in the centre of the patches there was a distinct tendency to scaliness. These patches were united across the nose by a broad band of disease which involved almost the whole of the skin of the nose and extended down on to the upper lip, where there was a superficial patch, about the size of a sixpence, which was distinctly scaly. The mucous membrane of the nose near the orifice was involved, and the nasal septum was perforated near its lower and anterior margins and there was slight necrosis of the

column between the nasal orifices. There were no other tubercular manifestations, and no history of tuberculosis in the family.

The disease was first noticed by the patient at the orifice of the left nostril on the inner side, when she was 29 years of age. She attributed the commencement of it to having been out on a cold night and having got her nose frost-bitten. The patient had a weak peripheral circulation, and suffered from cold feet, but rarely had chilblains. The disease gradually spread from the mucous orifice over the skin of the nose. It persisted in that situation for seven years and during that time was twice scraped at the hospital at Plymouth, and the perforation of the septum was said to have been done by a caustic pencil. After that the disease extended outwards till it reached its present extent. Three months ago she went under treatment with the Finsen rays at Plymouth, and had in all nineteen exposures, but the diseased area did not react well to the rays.

She had been under the same treatment at Charing Cross Hospital and had had about a dozen exposures, but the reactions had been invariably feeble and no distinct benefit had as yet accrued from them.

The case was of special interest owing to the difficulties which it presented with regard to the diagnosis from Lupus erythematosus. The situation of the disease, its age of incidence, the scaliness of several of the lesions, and the marked resistance to treatment with the Finsen rays, all suggested the possibility of its being a case of Lupus erythematosus; on the other hand, the presence of the somewhat translucent granulomatous nodules in the malar regions, and the loss of tissue in the septum and at the nasal orifice were strongly in favour of ordinary lupus. A small piece of tissue was excised from the left cheek, including a small granulomatous nodule, and this revealed, on microscopical examination, a diffuse granuloma situated superficially in the corium with occasional giant-cells, and decided the diagnosis in favour of Lupus vulgaris.

Dr. ORMEROD showed (for Sir DYCE DUCKWORTH) a man, aged 51, suffering from a *vegetating bullous eruption*. The patient was a game-keeper and had been healthy most of his life. He had been subject to pains in the limbs for ten years since he had caught a "chill." He had also injured his hand and had erysipelas in it nine years ago. The present trouble began about seven months ago with a sore throat,

and ulceration of the tongue, cheeks and gums and subsequently of the lower lip. Shortly after this his feet became swollen and blisters formed on them nearly as large as pigeons' eggs. Two outbreaks of these blisters occurred and when they healed they left his feet darkened and thickened. The eruption then spread up the legs into the groins, scrotum and hips, beginning on the hips as large red circles, a half to one inch in diameter, on which blisters subsequently formed. The upper extremities became affected three and a half months ago.

When shown his condition was as follows :—The mouth-cavity presents many superficial erosions with a greyish floor, affecting especially the insides of the lips, and the buccal mucous membrane along the border of the teeth, while there is a transverse fissure of the tongue.

The fingers are deeply pigmented and the skin is thickened and stiffened on the sides and back while the palms show a most extreme amount of almost papillomatous hypertrophy of the epidermis, somewhat similar to that seen in *Acanthosis nigricans*. On the fronts of the wrists the epidermis is also much thickened and there are to be seen small groups of vesicles, about an eighth of an inch in diameter, some with frankly purulent contents, others slightly opaque, others again almost clear. On the flexures of the elbows there are largish, flattened, purplish infiltrations which do not give one the impression of being composed of epidermic thickening alone, but suggest a definite accumulation in the corium. They are mostly the size of a large haricot bean and strongly resemble the patches seen in hypertrophic *Lichen planus*. They are quite dry on the surface. In the axillæ almost the whole of the skin is converted into a thick sheet of similar patches which have run together for most part, but are surrounded by large hard papules. The surface is eroded here, and the discharge was very offensive until carefully cleaned off. Remains of bullæ are to be seen, but no entire bullæ or vesicles are now present. On the abdomen there are a few scattered papules and round the umbilicus there is a group of pigmented macules as large as a hemp seed. The groins exactly resemble the axillæ with the exception that the patches are more prominent. The condition of the legs is very similar to that of the arms, but the patches are more numerous and perhaps even more suggestive of hypertrophic *Lichen planus* in their appearance. The soles show

the same spiny hypertrophy that is seen on the hands. In addition to these lesions the whole of the skin of the body and extremities is deeply pigmented, and on the thighs, buttocks, and shoulders are some red, raised rings and gyrate patterns, consisting of an œdematous swelling of the corium. It appeared to be on such rings as these that the bullæ actually formed. Since he has been in hospital (a little over a month) his condition has changed for the better owing to frequent baths of borax and bran, followed by inunction with liquid paraffin. Bullæ have been observed appearing in the axillæ on the outer limits of the pigmented and infiltrated areas. They were at first as large as a pea, with quite clear contents, and subsequently becoming cloudy. They then ruptured, leaving a raw surface which coalesced with the older infiltrated patches and thus caused the extension of the disease.

The diagnosis offered was that of *Pemphigus vegetans*.

A very great interest was shown in this case and a considerable discussion followed, many of the members having seen the case before exhibition while he was in hospital.

The diagnosis offered was generally agreed with, but Dr. Radcliffe-Crocker inclined rather to Hallopeau's *Pyodermatitis vegetans*. Dr. Colcott Fox remarked that although he was not aware of any case published in which the extraordinary condition of the palms had been noted, he would remind the members that hyperkeratosis of the palms had been occasionally seen in ordinary pemphigus and had generally been regarded as due to arsenic, but he was very doubtful if hyperkeratosis could not appear in pemphigus without the use of drugs. Dr. Whitfield said that when he saw the patient in St. Bartholomew's Hospital there were present bullæ containing perfectly pure serum, and that he could confirm Dr. Ormerod's opinion in this particular. He, therefore, thought that the case belonged to the true *Pemphigus vegetans* rather than to Hallopeau's disease, and he would remind the members that Hallopeau had now admitted his disease to be a sub-variety of that described by Neumann.

Dr. J. J. PRINGLE brought forward (1) a case of *Hydroa herpetiforme* in a highly neurotic and alcoholic man, aged 27, an actor by profession. The eruption first appeared on the lips in the beginning of January, 1902, and was very copious when he came under observa-

tion, and was admitted to hospital on August 7th. It was present in greatest abundance in both groins, popliteal spaces and axillæ, as well as over the face, especially in the beard region. Scattered vesicular lesions were also present over both upper and lower limbs, and a few existed on both palms and soles. The conjunctivæ were intensely chemosed, and there was extreme photophobia, but without corneal changes. Numerous large vesicles were also present over the hard and soft palate, and there was much superficial ulceration of the labial and buccal mucous membrane. In the large flexures, where the disease was at its maximum of intensity, there was much pus infection, the patient having, previous to coming under observation, been grossly neglecting himself. These regions, therefore, presented tracts of severe, conglomerate pustular dermatitis with some apparent papillary hypertrophy, and exhaled a most offensive odour. Round the margins of these patches, the essential vesicular and bullous elements could be distinguished, but at that time no characteristic grouping was present either there or about the scattered vesicles over the limbs. Considerable itching was complained of. The existence of moderate eosinophilia was noted. The urine was normal, the tongue coated, the digestion greatly impaired, and there was much emotionalism and insomnia. The condition of the mouth and large flexures suggested the possibility of the case proving to be one of early Pemphigus vegetans, or Hallopeau's *Dermatite pustuleuse végétante*, but these ideas were soon dispelled by the rapid and decisive improvement under treatment by prolonged daily boric baths with mild ammoniated mercury ointments in the intervals. Adrenalin was used with advantage for the eyes, and arsenic was given in moderate doses internally. He was sufficiently well to be sent to the Convalescent Home on September 4th, but relapsed, and was readmitted to hospital on November 14th, with a recurrence of all the manifestations of his disease, although in a much less severe degree than when first seen. Again he rapidly improved under the same treatment as previously, but two days previous to exhibition a considerable number of fresh erythematous and vesiculo-bullous lesions had shown themselves round the main patches of disease in the groins and in the lumbo-sacral regions, where the "cockade-like" arrangement, in concentric circles, was fairly well marked.

(2) and (3). Two cases which he designated provisionally as "*Seborrhoides*."

The first was a lad, aged 20 years, by occupation a barman, who came from a considerable distance in the country, and who had only been seen once by the exhibitor. He stated that the eruption, as it now presented itself, appeared two years ago and took only two days to develop and attain its present characters and extent of distribution. He was a particularly robust-looking fellow "who had never been laid up a day in his life," of more than average hospital-patient intelligence, and he strenuously denied all possibility of syphilitic infection. Subsequent cross-examination, however, invalidated the accuracy of his statements.

Over the trunk and limbs he exhibited a copious, diffuse, figured seborrhoic eruption with much dirty yellow scaling and festooned margins; here and there were circinate figures, the *ensemble* presenting a fairly typical "seborrhoea corporis," or "flannel rash." This eruption ceased abruptly at the level of the collar-band round the neck and at the bend of the elbows, which latter demarcation may probably have been due to the fact that he worked much in beer with his sleeves turned up to that exact level. On the left cheek, just above the angle of the mouth, there was a ringed, scaly seborrhoic patch the size of a florin; there was a negligible amount of dry seborrhoea of the scalp. The eruption spread from the trunk over the thighs in the form of ill-defined, scaly and circinate patches, which became more sparse as they were traced downwards, and ceased entirely in the middle of the legs.

In addition to the condition thus briefly sketched, and constituting the point of interest and dubiety in the case, there were present a large number of flat, yellowish-brown papules averaging about the size of a section of a split-pea, arranged without any grouping over the area affected with the seborrhoic dermatitis, and on no other part of the body. The resemblance of these to recent syphilitic papules was obvious at a glance, but careful examination failed to discover any primary sore or glandular enlargements, nor was there any evidence of syphilis in the throat or elsewhere.

Microscopical examination of a papule excised from the abdomen did not satisfactorily clear up the diagnosis. The amount of engorgement of the superficial vessels, with some thickening of their coats

and perivascular infiltration, were suggestive of early syphilitic change, but the degree of granuloma present was very slight as compared with the condition typical of an early papular syphilide. On the other hand, there was no special involvement of the sebaceous apparatus, and the epidermic layers presented no abnormality.

Anti-syphilitic treatment will be tried, and its effect reported upon.

The second case was that of a man, aged 31, by occupation a tailor, who presented an anomalous rash of "seborrhoic" type stated to be of five weeks' duration. It first appeared in the lumbar and gluteal regions, then over the shoulders and arms, lastly in the popliteal spaces. Its distribution in all these regions was remarkably symmetrical. Only a few ill-defined, scaly patches existed in the presternal region, while the face, scalp, back, hands and feet were absolutely unaffected. The elementary lesions in all the aforementioned regions were slightly elevated, slightly scaly and flat-topped papules, grouped in places to form circinate patches, in others coalescing to make up diffuse plaques with convex boundary lines. Many of the outlying patches were oval, and suggestive of Pityriasis rosea. A deep diffuse erythematous blush was present over the entire anterior surface of the right arm, connecting the lesions described, and a similar condition, but to a much less degree, obtained over the left arm, where a peculiar "striped" patterning of the eruption, with some atrophic crinkling of the epidermis, gave a curious semblance to an early case of Parakeratosis variegata (also noted by Dr. Radcliffe-Crocker). The subjective symptoms complained of were burning and slight itching. No microscopic examination had been made, the patient having been only once seen by the exhibitor.

In neither of the two cases was a definite diagnosis made by any member present.

(4) A girl, aged 18, suffering from a *follicular eruption* covering the back from the neck downwards and extending over the buttocks and posterior aspect of the thighs, knees and legs. She had cicatrices of numerous old scrofulous glands in the neck, and an acutely suppurating gland causing a marked fluctuating prominence beneath the ramus of the right lower jaw, stated to be of several months' duration. On account of it she had three months ago consulted a chemist,

who advertised a "safe cure" for scrofula, and the rash appeared two days after taking his medicine, to which she attributed it.

At the upper part of the back the lesions, which were minutely papular and all obviously follicular, were more sparsely distributed than elsewhere, and some racemose grouping was perceptible. Over the rest of the affected area the papules were so closely aggregated that all grouping was obliterated; many of them were covered by thin, adherent scales, and the colour of the conglomerate plaques was a deep purplish-brown, similar to that shown in many cases of Lichen planus.

At the right angle of the mouth was a deeply ulcerated papule, and at the upper part of the right tonsil a shallow, small ulcer with sloughy base. There was no detectable sore on the vulva, and no enlargement of glands, but the bulk of evidence seemed to point to the diagnosis of a *minute papular syphilide*.

The exhibitor's diagnosis was strongly supported by Dr. Radcliffe-Crocker and Dr. Galloway; but Dr. Colcott Fox and Dr. Whitfield thought the eruption might be a tuberculide, as in a very similar case recently shown by Dr. Pringle, in which his diagnosis of a tuberculide had been borne out by the subsequent progress of the case. There was a general consensus of opinion that on the ground of the objective characters of the eruption alone no firm diagnosis could be established.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, November 26th, Dr. STOWERS in the Chair.

Dr. EDDOWES showed (1) a middle-aged man suffering from a *pigmented papular eruption* affecting all parts of the skin except that of the face. It was the sequel of a general exfoliative dermatitis from which the patient suffered last May when Dr. Eddowes first attended him. The patient stated that he did not remember having had a day's illness until a year ago (November, 1901). He first felt a little itching area on the lower part of his back. He scratched it a good deal, but thought little of it until it gradually extended towards his right groin. In May it became rapidly worse, and he was admitted into the hospital, where he went through the severe condition of general exfoliative derma-

titis, shedding the whole of his hair in the process. In time he improved, his hair grew again and he went to the country to regain strength. It had been suggested by some of the members that the present condition was that of *Mycosis fungoides*, but with that diagnosis he was not disposed to agree. Others had suggested that it was a lichen, and that suggestion was interesting, because the peculiar distribution of the rash as well as other features suggested a close resemblance to Unna's *Parakeratosis variegata* which many English dermatologists termed lichen or inflamed lichen. He would obtain sections for microscopic examination, and bring the case before the Society again at a subsequent meeting.

The PRESIDENT said he would be glad if Dr. Eddowes would have a good coloured drawing made of the case for inclusion in the Society's album. It would be especially valuable, because it showed a combination of conditions common to so many ailments. It reminded him of a case of *Dermatitis herpetiformis* which he saw about five years ago. The possibility of its having commenced as *Lichen planus* was to be borne in mind. On the inner aspects of the wrists there were thickenings having very much the character of hypertrophic *Lichen planus*.

Dr. EDDOWES said he would be much pleased to arrange for the Society's artist to take a coloured drawing of the case, which was certainly rare, and he would undertake to accompany it with fuller notes.

(2) A case of *Dermatitis hiemalis*, previously referred to, which exhibited several circular lesions varying from the size of a three-penny piece to that of a shilling, situated on the backs of the hands; each lesion seemed to commence with the formation of a group of closely packed, rather deeply-seated tense vesicles. In the course of a week the patches dried, the horny layers split up and exfoliated, leaving a red and slightly scaly base surrounded by the rough, circular border of horny substance which abruptly ceased to exfoliate just outside the inflammatory area. The patient never had chilblains; this winter-complaint seemed to be brought about by cold independently of occupation. It was so probable that alkalis at least aggravated this case that Dr. Eddowes had employed an acid ointment and rapid improvement had resulted therefrom.

Dr. GRAHAM LITTLE showed (1) *a case for diagnosis*. The patient was a man aged about 30, who at the present time was employed as a barman, but who up to the last three months and for three years previously had been a soldier in South Africa. Six months after he

occurred in South Africa in the morning in the rain and happened to occur in the middle of the night when the patient had apparently been asleep for some time. The hand was not injured at the time and the wound appeared and did not heal. From the time the wound was made the whole palm of the hand had become affected and it presented the appearance of an irritated scaly eruption covering the entire palm. It had persisted in this condition for about two years. There were no lesions of any kind elsewhere, and the man had enjoyed perfect health throughout the eruption, except that he had had two vein-aches which had healed spontaneously. He had had gonorrhoea but not syphilis, and presented no symptoms of the latter disease. There was hardly enough inflammation for a tubercular infection. But there was a history of his having, a few days after the accident, picked up a pair of gloves in Bloemfontein, and having worn these. Bloemfontein has for many years been the favourite resort in South Africa for consumptives, and probably reeks with tuberculosis. Some scrapings from the scaly patch on the palm had been examined bacteriologically, and had yielded cultures of ordinary staphylococcus.

(2) A case of a chronic eruption occurring as small nummular patches distributed over the greater part of the body in a boy of ten. The patient had been shown by Dr. Dore at the London Society, and the general diagnosis there had been that of Parakeratosis variegata of the type described by Brocq as "*Parapsoriasis en gouttes*." The rash had lasted unchanged for two years. It was not itchy, and caused no disturbance of health.

The President said the Society was much indebted to Dr. Graham Little for showing such a very rare disease, which ought to be studied in relation to Brocq's own writings on the subject. He hoped Dr. Little would show the case again later, not from the point of view of diagnosis, but to exhibit the effect of treatment.

Mr. ARTHUR SHILLITOE showed a case of recurrent node of the right frontal bone. Syphilis was acquired in November, 1888. At the end of eight weeks' treatment at St. Peter's, the patient states that his body was covered with spots and sores which were hard, and exuding black blood, together with some large, deep ulcers with whitish matter. He attended under Mr. Hurry Fenwick for two years, and again on many occasions during the next five years for

gummata of the knee, testicles, &c. In 1896 he married. In August, 1897, he had severe and continuous headaches over the right temple, and was treated by a doctor for rheumatism. He got rapidly worse, and his head visibly increased in size, and he was obliged to give up his employment. In January, 1898, he attended at the Lock Hospital, and under Mr. Arthur Ward's care he so rapidly improved that he was able to resume his occupation.

The present trouble is entirely a local one. If he omits the mixture for more than forty-eight hours the relapse of the node straightway supervenes. He is occasionally laid up with attacks of asthma and bronchitis. At these times the mixture is not taken, and the node does not relapse.

His wife and two children are perfectly healthy.

The PRESIDENT said this was a case in which it would be necessary to administer the remedies as long as benefit was obtained. He was not aware of any drugs more likely to be of use than those employed, but they should be administered in maximum doses.

Dr. WILFRID WARDE suggested that it was a case in which mercurial injections might do good, a treatment which was recommended by Fournier in just this kind of case.

Dr. STAINER showed three cases of *Sclerodermia*. The first patient, a married female, aged 35, showed areas of pigmented circumscribed sclerodermia on the left side of the chest, immediately below the breast.

These patches had first appeared about thirteen months previously, and at present were spreading slightly in spite of treatment by X-rays, and latterly by the internal use of thyroid gland extract.

The second case, a girl aged 16, showed the disease as a streak without pigmentation, extending from the upper third of the left thigh downwards across the knee and along the tibia, stopping just short of the ankle.

There was a three years' history, and the disease was now rapidly disappearing. The patient was at present taking thyroid gland extract, but previously had had X-ray treatment.

The third case, a girl aged 18, also with a three years' history, showed the disease in an unusual position—namely, at the angle of the mouth on the right side. From this situation the patch extended along the edge of the mucous membrane to the middle of the lip.

The patch was showing signs of spreading to the left side, although the patient was having X-ray treatment.

The X-ray treatment in these cases had been carried out by Dr. Greg at St. Thomas's Hospital.

Dr. ABRAHAM asked whether Dr. Stainer admitted any nerve-origin in those cases. Two or three cases which he (Dr. Abraham) had shown before the Society gave a history of shock, or a fall, or an injury some little time before the lesions started. Thyroid extract seemed a successful treatment in some cases, but not in all. As in the case of psoriasis, one could never say beforehand whether it was likely to do good in any given instance. He suggested treating the localised patches by means of the high frequency current.

Dr. SAVILL congratulated Dr. Stainer on showing three cases together of such a rare condition. He thought the case of the girl aged 16 was particularly interesting, in whom the lesion on the leg very exactly resembled the lesions existing in a case shown by Dr. Harry Campbell at the last clinical meeting of the Clinical Society, which Dr. Campbell had described as a case "of the type of hemiatrophy facialis." He (Dr. Savill) took exception to the term because it did not indicate the nature of the disease. That patient, like the one now before the Dermatological Society, presented lesions on different parts of the body which he (Dr. Savill) had been accustomed to regard as scleroderma, and which he believed to be the same as the "morphœa" described by Sir Erasmus Wilson. The latter had described two varieties, morphœa alba, and morphœa nigra. Sir William Gowers had suggested the term "panatrophie" in view of the wasting of all the tissues beneath the skin. He thought that in all such cases some injury or trophic lesion could be traced, probably in the ganglion of the nerves supplying that area. As to treatment, both X-rays and thyroid extract had done good in some cases, but the disease was usually stubborn.

Dr. EDDOWES referred to a man whom he showed three years ago, who was the subject of general alopecia which had commenced in childhood. Some years later some large tracts of melanoderma had developed, succeeded by leucoderma, in addition to which some patches of morphœa alba formed, as well as larger and deeper patches of scleroderma. He had had the advantage of watching that patient for several years, and showed him at the annual meeting of the British Medical Association held last year at Cheltenham. He himself and all those present who compared the patient with the drawing that had been taken two years previously were surprised to see the change for the better which had taken place. The melanoderma had become paler, and much of the leucoderma had practically given way to normal flesh colour, but the most surprising change had taken place in the sclerodermic areas, several of which, on losing their hardness, threatened marked atrophic depressions. Not only had the hardness disappeared, but the depressed skin had practically recovered its normal level. The patient felt perfectly well, and exhibited no apparent neurosis, therefore a very simple line of treatment had been followed: massage and friction with a compound sulphur ointment.

The PRESIDENT suggested that Dr. Stainer should persist for a longer period in the treatment he had adopted, if he thought it fair to the patient. Experience of the treatment of scleroderma by X-rays was too limited to enable definite con-

clusions to be formed. In one of the cases he understood the disease was spreading, despite the use of the X-rays. If the present line of treatment did not prove satisfactory, perhaps a combination of massage and electricity might be tried with advantage.

Dr. STAINER, in reply, said he had been unable to obtain a history of either injury or shock in these three cases.

The patient with the lesion on the leg had not been able to use that leg, owing to the pain and stiffness caused by the extension of the disease directly over the knee-joint. Now that the disease was disappearing walking was no longer painful.

The breast case had had X-ray treatment for a long period, and it was decided that it was useless to continue it.

The leg case was improving under X-rays, but was still showing marked improvement with thyroid extract.

Dr. WILFRID WARDE showed a case of *Turpentine eruption* in a young man, aged 27, by occupation a printer, who had suffered from the eruption now seen on his hands and forearms for seven years. The essential lesion was a small phlyctenule, a diamond-shaped vesicle standing on an inflamed base, but the lesions tended to leave small white scars. When he first saw the patient the eruption was fairly abundant, entirely confined to the backs of his hands, and the forearms, and he understood that that had been the distribution from the first. The phlyctenules had in places aggregated together to form patches, two of the patches being of the size of a shilling, having in the centre a pale red depressed surface with shiny skin, and round it a circle of elevations, each capped by a small vesicle. At that time there were on the backs of the hands a large number of small white scars, but under the influence of treatment they seemed to be much less conspicuous now than at first. The lesions on the forearm took the form of exudations, which appeared to lift up the whole of the epidermis, and form tiny figured areas. The patient in the course of his occupation handled turpentine and ammonia, and possibly it was a case of turpentine dermatitis. His nails were very thin and incurved. He had been treated with pyrogallie acid.

Dr. ABRAHAM said there seemed to be a keratosis in the younger papules, and he thought Dr. Warde's idea was the correct one—namely, that it was due to the irritation of turpentine. Such conditions were sometimes seen in paraffin dermatoses.

Dr. ALFRED EDDOWES said that the condition reminded him of a few cases which he had seen of follicular inflammation produced on the arms and hands by varnishes

and tar. He had shown to-day a barber suffering from *Dermatitis hiemalis* on the backs of his hands for the fourth consecutive winter. It would interest members to compare the latter with the case now shown.

The PRESIDENT thought the lack of uniformity in the lesions made it difficult to arrive at an exact diagnosis, but he did not doubt that the explanation offered was a correct one.

The PRESIDENT then delivered his address on *Mycosis fungoides*, which will be published in a future number of this Journal.

CURRENT LITERATURE.

THE INITIAL STAGES OF LICHEN RUBER PLANUS. PINKUS. (*Archiv f. Dermat. u. Syph.*, May, 1902, p. 168. Three Plates.)

THIS paper is the result of a series of histological examinations of newly formed lesions of Lichen planus. The writer has been careful to excise only lesions which were fresh and not those which had coalesced or in which hypertrophic changes had supervened.

The chief point at issue with regard to the histology of Lichen planus at the present time is the nature of the small cells which form the infiltration in the cutis. These are regarded by certain authors as lymphocytes, while others consider them to be plasma-cells, and a third group of observers assert that they are chiefly derived from the endothelium of the vessels. Pinkus regards the infiltration as merely inflammatory and consisting not only of numbers of mononuclear leucocytes, but also near the epidermis of polynuclear leucocytes. He regards the presence of the latter as very characteristic of the infiltration of Lichen planus. The changes in the epidermis, which he describes, are those which are well known in association with the disease. He observes that the vesicles which may occur in Lichen planus may be situated either superficially or deeply in the epidermis, or may be found between the epidermis and the corium.

J. M. H. M.

A CASE OF LICHEN RUBER MONILIFORMIS FOLLOWING THE DISTRIBUTION OF THE SUBCUTANEOUS VEINS. GUNSETT. (*Archiv f. Dermat. u. Syph.*, May, 1902, p. 179. Two Plates.)

THE writer reports a case of Lichen moniliformis (Kaposi) which occurred in a woman aged 65 years. The case was peculiar in that the rows of lesions closely followed the distribution of the subcutaneous veins of the thighs. The appearance which the thighs presented was as if the superficial branches of the great saphenous and inferior epigastric veins were dilated and varicose, but instead of presenting the ordinary bluish lines, formed brownish-red lines made up of small round and polygonal lesions similar to those of Lichen moniliformis of Kaposi. The lesions were arranged like the beads in a rosary, except about the knees and front

of the ankles, where they were grouped. A few of the lesions were scaly or crusted. A somewhat similar condition was present on the extensor aspect of the forearms. A histological examination revealed a hyperplasia of the cells of the stratum Malpighii, hyperkeratosis with the formation of "horny pearls," and colloid degeneration of the prickle-cells. In the cutis there was a small-celled infiltration of the papillary and sub-papillary layers which ended in a sharp line near the basal layer. The veins of the papillæ were markedly dilated.

J. M. H. M.

HÆMANGENDOTHELIOMA CUTIS PAPULOSUM. WALDHEIM. (*Archiv f. Dermat. u. Syph.*, May, 1902, p. 225. One Plate.)

THE patient, who forms the subject of this contribution, was a tailor, aged 48 years. On both sides of his chest he had a small papular eruption irregularly distributed and extending from the clavicles as far down as the level of the umbilicus. The individual lesions were papules which varied in size from a pin's head to a split-pea. They were roundish or oval, smooth on the surface and pale in colour, and somewhat translucent. At first sight they suggested the lesions of syringo-cystoma.

On microscopical examination the papule was found to be the result of a cellular infiltration, which was confined to the corium and spread down in lines corresponding to the distribution of the blood-vessels. Associated with these cellular streaks were circular collections of cells and a number of cysts. By higher powers of the microscope the cells were found to be endothelial cells, and the cysts to be the result of a colloidal degeneration of clumps of cells. The endothelium of the vessels had proliferated, and here and there blocked the vessels, and the central cells had undergone a colloidal degeneration. The condition was that which Jarisch has named Hæmangio-endothelioma tuberosum multiplex, and which has gone under a variety of names such as Lymphangioma tuberosum multiplex (Kaposi), Endothelioma tuberosum colloides (Kromayer), &c.

J. M. H. M.

ON COLLOID DEGENERATION OF THE SKIN, SPECIALLY IN GRANULATION AND SCAR TISSUE. JULIUSBERG. (*Archiv f. Dermat. u. Syph.*, August, 1902, p. 175. One Plate.)

WHILE assistant in the dermatological clinic at Berne the writer had the opportunity of studying two cases of this peculiar degeneration of the skin affecting scar tissue. The first case was that of a woman, aged 58, who had a serpiginous syphilide on the neck, and associated with this a raised yellowish translucent plaque about the size of a three-mark piece and clearly demarcated from the surrounding skin. Besides this case and another somewhat similar one, the writer saw a third case at Breslau. He made a histological examination of the three cases and got similar appearances in each. He found that the yellowish discolouration was due neither to pigment in the skin nor to cell-masses like those of Xanthoma, but that it was the result of a degeneration of the fibrous elements in the corium similar to that which occurs in the condition known as "colloid milium." He notes that the same type of degeneration occurs in (1) colloid milium; (2) Xanthoma elasticum; and (3) in scar tissue.

J. M. H. M.

FOUR CASES OF PINTA IN EGYPT. FRANK COLE MADDEN and CYRIL GOODMAN. (*Records of the Egyptian Government School of Medicine*, 1901, p. 199.)

THIS short paper is illustrated by two plates showing the clinical appearances, which in Case I. (a Soudanese) certainly look at first sight like leucoderma, a fact which had struck the authors, but the skin in the centre of the white patches was abnormal, for not only had it lost its pigment, but it showed signs of inflammatory redness, fading on pressure, and was very superficially scarred. As to the scalp, the patch of disease extended from the forehead as far back as the occipital protuberance.

The authors state, too, that the appearances on the face somewhat resembled Lupus erythematosus, and to complicate matters there was a single favus scutulum on the right margin of the main patch. The hairs of the beard and moustache in the affected areas were quite white. Whilst in hospital, the skin over the chest and abdomen became covered with brown, brawny scales, heaped up in small patches. The scaling was very marked on the sides of the chest. The arms down to the elbows were similarly affected, but the legs were quite free. This scaly development was accompanied by great itching. There was no distinct odour, and although scales were repeatedly examined microscopically no fungus was found.

CASE II. was an Egyptian boy, aged 16, from Lower Egypt. It started as a reddish patch under the left eye and invaded the right side of the face, right ear and back of neck. Duration, six months. The eyebrows and eyelashes became white. No fungus was ever found.

Two other cases are also briefly mentioned.

The authors, as far as they know, think these are the first cases of the kind reported in Egypt, and further remark that Pinta has not the limited geographical distribution generally assigned to it.

In this connection I may mention that in the second edition (1900) of his "Tropical Diseases," Dr. Patrick Manson states, under Pinta, that lately a similar disease has been seen in North Africa, and described by Legrain (in *Arch. de Parasit.*, January, 1898). This latter writer states that it commences with pronounced fever lasting for a week, followed by malaise, itching and furfuraceous desquamation. It is certainly not vitiligo. In Tripoli, Legrain has seen a coloured skin-disease with features of true pinta, but he has never found the fungus in the scrapings. Manson adds that this is possibly the disease referred to by Sandwith in *Journ. Trop. Med.*, 1899, as having been seen by him in Egypt.

In Madden's case I. (*supra*), the patient was in bed for three days with fever at the beginning of his illness.

GEORGE PERNET.

EDITORIAL NOTICE.

THE Editors beg to announce the following alterations in the Staff of the Journal. The Quarterly Survey of Current Literature, which until recently has been under the charge of Mr. George Pernet, has been undertaken by Dr. Edward Stainer, and the Index, which has been the work of Dr. Cecil Bosanquet, by Dr. J. H. Sequeira. The Editors wish to take this opportunity of thanking Dr. Bosanquet and Mr. Pernet for their valuable co-operation in these branches of the work of the Journal.



UNDER LOW POWER. SHOWING CELLULAR INFILTRATION ROUND PILO
SEBACEOUS APPARATUS.

THE BRITISH JOURNAL OF DERMATOLOGY.

FEBRUARY, 1908.

A RARE SEBORRHOÏDE OF THE FACE.

By J. J. PRINGLE.

THE accompanying coloured illustration faithfully depicts the condition of Mrs. S., a housekeeper, aged 39, who was exhibited at the Dermatological Society of London on June 11th, 1902, and briefly reported in this Journal (July No., p. 269). As the case presented a rare clinical type of disease, not previously illustrated in any publication, it was decided to publish a full account and drawing of it; the more so as material had been obtained for microscopical examination which afforded an opportunity for settling some doubts raised at the meeting as to the exact seat and nature of its elemental lesions.

The patient, who first came to the Middlesex Hospital on December 31st, 1901, was a highly intelligent woman, much depressed in mind owing to the disfiguring malady, which greatly interfered with her work and evoked much arrowed criticism on the part of her neighbours. Her hair was brownish, her irides blue-grey. She stated that she had suffered for many years from severe indigestion, the prominent symptoms of which were flushing of the face and a sense of fulness after food, with flatulence, heartburn and acid eructations, but without loss of appetite or constipation, and without gastric pain or tenderness. The tongue was clean but flabby, the teeth were good. No physical examination of the stomach was carried out. As housekeeper in a large trade establishment she had

to superintend the cooking and was much exposed to the fire. She stated that she was a total abstainer from alcohol, but drank large quantities of tea not prepared on true hygienic principles. Her eruption had appeared somewhat suddenly at the end of October or the beginning of November on the sides of the nose and soon afterwards on the chin; subsequently it had spread from the nose over the forehead and cheeks, but only a few days previous to coming under observation had it assumed its then severity and universality of distribution as regards the face. Her scalp was noted as being somewhat pityriasic and her entire face the seat of a severe general desquamative dermatitis which, truth to tell, excited little special interest.

The case was labelled "Seborrhoic eczema" of the face, and a bitter-alkaline mixture with *nux vomica* was ordered to be taken three times daily before meals. *Spiritus saponis alkalinus* was prescribed for the scalp daily. The dietary was regulated on the lines usual for a case of atonic dyspepsia. On January 28th a bismuth and sulphate of soda mixture was substituted and five grains of ichthyol in capsule, three times daily after food, were added. A simple lanoline cream was also prescribed for the face. Under this treatment she improved markedly, but owing to the imperfection of the out-patient notes it is impossible to say exactly at what date the general dermatitis of the face sufficiently cleared up so as to disclose the manifest peculiarities of the underlying and doubtless essential condition.

At all events, on May 18th it was noted that she showed a bat's-wing patch of rosacea over the nose and cheeks, while the rest of the face was studded with lesions suggestive of sebaceous adenomata. The unusual features of the case now manifest prompted its demonstration as a "case for diagnosis" at the Dermatological Society, and the condition at that time may be described as follows in an amplified form of the previously published note:—

"The disease occupies the whole of the face, its brunt having fallen upon the nose and malar regions and, to a less degree, on the forehead. The upper eyelids are, however, nearly free from disease and the lower eyelids only slightly involved. The conjunctivæ, vermilion of the lips and buccal mucous membranes are absolutely normal. A considerable number of lesions are present on the front

and sides of the neck in a band two or three inches broad parallel to the lower jaw, and they extend over the sterno-mastoid into the post-auricular regions; the lobes of both ears are moderately affected. The lesions not situated on the face have all evolved during the past fortnight under observation and without any manifestations of the previously existent dermatitis. The skin of the nose and adjacent parts is somewhat shiny, but is not markedly oily to touch, nor is there any local hyperidrosis. The face exhibits an obvious rosaceous condition of bat's-wing distribution, extending to the outer limits of the flush patch on both sides, which since coming under observation has been noticed to vary greatly in intensity, being at present at its minimum. Over the same area there are a considerable number of apparently permanent telangiectases, punctate, linear and stellar.

“The characteristic feature of the case is the presence of innumerable, small, nodular prominences which are superadded to the rosaceous condition, and extend outside it to thickly cover the whole face as well as the contiguous part of the neck. They vary in size from a pin's point to a split-pea, and are most closely aggregated over the rosaceous area, where they participate in the bright red colour of the part. On the nose several nodules are so closely grouped as to simulate their coalescence, but the outline of each particular nodule can be clearly made out on careful examination. The smallest elements are present in myriads over the forehead, every follicle being apparently “picked out” by them, and a sensation of roughness is imparted to the finger passed over the region. Their colour being brownish, and the intervening skin pink from congestion, a peculiar effect of fine stripping is produced, and a certain amount of very fine pitting can be determined. The condition ceased abruptly at the margin of the scalp.

“Over the cheeks—outside the malar regions—lips and chin, the lesions are much larger and more sparse in distribution. They rise abruptly from the general skin level, are firm to the touch, and their rounded summits refract light brilliantly so that an appearance of vesiculation is simulated. The majority are bright pink in colour, but when congestion is reduced by digital pressure, their colour is brownish and their appearance gelatinous or colloid. On the neck the nodules are still more discrete in distribution, and their general

colour less vivid. Nowhere is there any comedo formation, vesiculation or pustulation; nor is there any sign of absorption, or pitting or atrophy, resulting from these larger lesions, all of which are in a state of evolution rather than regression. The scalp, which has been vigorously treated, shows a trifling amount of dry seborrhœa. There is no acne or other evidence of sebaceous disorder on the back or chest."

The case on exhibition was at once identified as similar in nature to one shown "for diagnosis" by Dr. Colcott Fox in 1894, and as presenting many points of analogy with one recently shown by Dr. Galloway, to both of which subsequent reference will be made.

A few days after exhibition a portion of skin, including some characteristic lesions, was excised from the upper part of the neck over the sterno-mastoid muscle, at the level of the angle of the jaw. The specimen was hardened in alcohol, embedded in paraffin, and submitted to histological examination by Dr. Graham Little, to whom I am indebted for the following report:—

"*Examination with a low power* (No. 3 Leitz):—the small elevations corresponding to the papules are seen to centre round a pilo-sebaceous follicle. The follicular orifice is not especially large or dilated, and there are no plugs, as in acne. The hair in the follicle is not coiled upon itself or abnormal in any way. The horny layer is normal; there is no acanthosis. The only pathological features noticeable are as follows:—Around the hair-follicle throughout its extent, but more especially in its deeper parts, there is an extensive infiltration of cells. In the case of the larger papules this mantle of cells exceeds two or three times the diameter of the cross-section of the follicle, as measured with a micrometer eyepiece; in the smaller papules the sheath of cells surrounding the follicle may consist of only a few layers of cells, but the hair-follicles, almost without exception, seem to have this surrounding envelope of cells. The collagenous bundles are displaced by these collections of cells, and wall them in. The sebaceous glands appear in many cases abnormally large, but this enlargement is in no way comparable to that seen in sebaceous adenoma. The blood-vessels appear normal and there is no other tissue-change to note.

"*Examination with a high power* ($\frac{1}{12}$ oil immersion, No. 4 eyepiece, Leitz):—the collections of cells round the pilo-sebaceous

follicles consist of mononuclear and polynuclear leucocytes, with some connective-tissue corpuscles. There are no plasma-cells or mast-cells. The most careful examination for micro-organisms gave a negative result."

The accompanying drawing accurately represents the appearances seen with the low power (No. 3 Leitz, eyepiece 4.)

The report of Dr. Fox's case (*Brit. Journ. of Derm.*, Vol. VI., 1894, p. 368) may be here literally transcribed.

Dr. Colcott Fox presented a girl (Lucy P.), aged 20, with a peculiar eruption of the face, for diagnosis. The girl was generally healthy, and had not suffered from any ill-health of moment, since contracting chicken-pox, measles and whooping-cough in childhood. Duration of the eruption two years. The cheeks were the seat of a miliary, indolent, deep-red papular eruption, developed apparently in connection with the follicles. In the central portions of the cheeks almost every follicle was involved, so that, with the added blush of the part from excitement, the cheeks appeared, when examined from a distance, to be uniformly red. There were no telangiectases. Over and beneath the jaw the lesions were comparatively few and discrete, and it was evident they did not enlarge peripherally. They were discrete, though numerous, on the forehead, and also on the chin. There were two behind the right ear, and one on the right upper eyelid. The right half of the face presented more lesions than the left. The upper lip and nose and lower eyelids were free. The papules varied somewhat in size, and presented rather a rounded top, often covered with a little scale. When the hyperæmia was pressed away, or a lesion was undergoing involution, a peculiar citron-yellow base was disclosed. The girl had been rubbing into the parts for a few weeks a mild sulphur ointment with some benefit. At any rate the scales had disappeared, and the papules had flattened down somewhat. Many lesions had undergone almost complete involution, and at the meeting it was very apparent that they left behind little slightly pigmented pits. There had been no trace of vesiculation or pustulation. In attempting to make a diagnosis, the exhibitor had passed in review Erasmus Wilson's folliculitis of the face, lupus erythematosus, acneiform lupus, colloid milium and seborrhœa.

As Dr. Colcott Fox had a water-colour drawing made of his case, which—with characteristic kindness and courtesy—he has given me ample opportunity for examining, I am satisfied that the case under consideration was an exaggerated example of the condition so long ago recognised by him as a subject for further study. The amount of telangiectasis present in my case as contrasted with its absence in Dr. Colcott Fox's, probably depended on the age and avocation of the patient; while the greater degree of pitting and atrophy in his case may be referred to its chronicity as contrasted with the comparative acuteness of attack in mine. Dr. Fox's

drawing also brings out the point that a certain amount of diffuse scaly dermatitis may complicate and mask the essential condition.

Dr. Galloway's case was reported as follows (*Brit. Journ. of Derm.*, Vol. XIV., p. 162) :—

Dr. Galloway showed a private patient, Miss W., who had been sent to him by Dr. Leslie, of Berley Heath, for an opinion. The patient was a young woman, 26 years of age, who gave no history of previous disease definitely bearing upon the present condition. She was well-developed and appeared to be in good health. She admitted that she suffered from a certain amount of dyspepsia, but this was not of great degree, and did not appear to have any influence on the condition to be mentioned. About five years previous to this date she had been exposed to severe cold, and very soon after the exposure, and, according to the patient's statement, on account of it, she commenced to manifest the present malady. Now, the patient presents, widely and symmetrically distributed over the face involving the central and lateral areas, the forehead, the chin, the upper part of the front of the neck, and also the lobules of the ears, an eruption consisting of papules, some of them distinctly elevated and other lesions consisting of small nodules more deeply situated in the skin. The lesions did not show much evidence of inflammation, and it is only by accident apparently that one or two of them have become pustular. On carefully examining the texture of the skin of the face almost every follicle appears to be affected, and over considerable areas, especially on the malar regions, a finely pitted appearance of the skin has resulted. In addition to the papular lesions there is a slight amount of general erythema, and on looking more carefully numerous telangiectases may be seen. Dr. Leslie states that the condition of telangiectasis has become much more developed recently. Dr. Galloway remarked that the general appearance of the skin of the face at the first glance resembled in colour some cases of Adenoma sebaceum, but on more carefully examining it was quite clear that this class of disease presented no real resemblance to that condition. The papular lesions appeared definitely to occur in the skin appendages, either in the sweat-duct or in the sebaceous follicle or duct. There was no evidence whatever of hidrocystoma.

While Dr. Galloway's case presented some superficial points of resemblance to mine, indicated at the meeting, I cannot but think that essentially the two conditions are different. In my case there was no approach to the "cribriform" or "worm-eaten" appearance—so familiar to all dermatologists, although as yet honoured by no specific designation—which constituted so marked a feature in Dr. Galloway's case, nor was there any suppuration. Indeed, I am inclined to think that the seat of the change in such cases as Dr. Galloway's is very probably the sweat-apparatus, as he himself surmised, although without any histological basis for his opinion.

Progress.—As Dr. Colcott Fox stated that his case soon recovered under treatment with a mild sulphur ointment, a similar application

was used in this case. Marked improvement at once set in. After a month, the progress having become somewhat tardy, a moderately strong sulphur-resorcin paste was substituted, under which rapid and complete recovery ensued, the patient's complexion becoming rather exceptionally delicate. It has remained so ever since, although occasional rosaceous flushings have occurred from time to time as the result of errors of diet.

It would be a matter of supererogation for readers of this Journal to labour the points of differential diagnosis between this condition and others, which by the tyro might be mistaken for it.

MYCOSIS FUNGOIDES.

By J. H. STOWERS, M.D.

BEING THE PRESIDENTIAL ADDRESS DELIVERED AT THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND, OCTOBER 22, 1902.

GENTLEMEN,—It is my pleasure and privilege to welcome you here again after the summer vacation, and I trust you are all fortified and invigorated by the benefits of holiday and rest. The time has come when we must devote ourselves again to the consideration of subjects appropriate to our Society. At our last meeting I briefly described to you the plan of procedure which I think is calculated to secure both the convenience of members and the comfort of the patients brought for exhibition. I may confidently appeal to you to help me, and the honorary secretaries to carry out that method as exactly as possible, in order that an equal opportunity may be afforded to all intending exhibitors, and that time may be economised. Perhaps those who were not present at the annual meeting in May will kindly refer to the report published in the *British Journal of Dermatology* of July, and read the preliminary remarks I made to you when, through your favour and indulgence, I was permitted to occupy this chair, as your President, for the first time.

I will repeat, however, that it will be of much benefit to us all if brief communications are occasionally read on points of interest

connected with a single disease, or class of diseases, as a basis for discussion, and also that the most important subject of treatment may be considered at greater length than hitherto.

It is very striking to note the advances that have been made of late years in practical dermatology.

This department of medicine which for so long a time was regarded with indifference, and treated I might almost say with the spirit of exclusiveness, has now by the diligence of its workers and their improved scientific methods of investigation been raised to a level which compares favourably with all other branches of the healing art. Its basis has been widened and its foundations strengthened proportionately as observers have realised the necessity of regarding diseases of the skin not merely as accidental to the surface of the body, but as expressions also of derangements of the whole economy consequent upon and inter-dependent with the innumerable disorders of function and structure to which the human subject is liable. The text-books we now possess include among their number treatises as detailed and complete as recent investigations will allow, and it is only fair and right that we should acknowledge the great and increasing usefulness of the *British Journal of Dermatology* which, under its accomplished editors, have proved so valuable a means of diffusing knowledge obtained from sources previously beyond our reach.

I need not here refer in detail to the numerous cases, some of great and unusual interest, which have been exhibited at this Society of recent years, but on reviewing the list it occurred to me that I might select one form of disease of special gravity which, from its very nature and the fact that no tried remedies have yet proved successful in coping with it, pleads pathetically for consideration. I refer to the disease known as Mycosis fungoides.

I exhibited here last session a patient suffering from this terrible malady whose history I will briefly repeat as it is quite a representative case.*

A curate in a large London parish, unmarried, aged 31 years, has been under my observation since November, 1901, having been sent to me by Dr. Kerr. His parents are living and in good health.

* Reported *Brit. Journ. of Derm.* (Society Intelligence: Derm. Soc. of Lond.), Vol. XIV., p. 63. (1902.)

Four brothers and four sisters are alive and well. None are affected by cutaneous disorders. The patient, who is an exceptionally well-developed and muscular man, was born in Somersetshire, and educated at Trent College and later at Broxham. In 1887 he went to Canada and engaged in farming occupations, and returned to England at the end of 1889. In 1892 he proceeded to Durham University to prepare for ordination.

At the time he was reading many hours a day, although in apparently perfect health and taking a fair amount of out-door exercise, a "red patch" appeared on the right forearm and remained. In 1893 "patches" of the same character developed symmetrically over the front of the chest and back. He was treated for psoriasis at Frome, where he stayed for several weeks. Not making satisfactory progress, he came to London for special advice and consulted several dermatologists, one of whom suspected the existence of leprosy, and prescribed chaulmoogra oil, and shortly afterwards another (Dr. Pringle), who suggested an early stage of *Mycosis fungoides*. Subsequently for three years he lived and worked at Exeter, during which time he was under medical care for what was taken to be urticaria. A limited patch of thickened skin upon the right cheek was thought to be of the nature of lupus by his attendant, but this disappeared entirely in a few months. In 1899 he came to London, since which date he has suffered, in addition, from a persistent subacute eczema involving the forehead, eyelids, cheek, and neck. When seen by me in November, 1901, his general health was good. He was well-nourished and complained only of anæmia and chronic constipation, both of which soon yielded to remedies. His urine was slightly phosphatic, but otherwise healthy. My notes at the time were as follows:—

A limited eczematoid eruption exists upon the face, especially involving the forehead, eyelids, and right cheek.

Upon the front of the chest and abdomen there is an extensive development of symmetrically arranged thickened patches with defined edges of different degrees of redness, varying in size from a sixpenny-piece to a florin. Some are discrete, but most of them are irregularly circular and show a tendency to coalesce. In parts where coalescence is complete the whole integument is infiltrated several inches in extent, the sharply defined edges being maintained.

Discoloured portions of skin exist, having a dullish red or pigmentary brown appearance, conveying the impression of former infiltrations in which absorption has taken place, the skin having a shrunken surface. The mottling is a striking feature of the case.

The shoulders, back, loins, buttocks and thighs are similarly involved, but to a lesser degree. In some patches the bright red or pink-coloured edges contrast considerably with the browner centres.

The integument of the legs exhibits an increasing tendency to the same abnormal change, but the thickening is less marked and numerous indications of recent scratching are present. The patient states that on one occasion an infiltrated patch above the navel exuded a whitish fluid of serous nature and partially subsided. There has been no ulceration at any time. For a long period the itching about the chest and abdomen particularly was "agonizing." Recently this has greatly diminished, but his rest at night is occasionally disturbed by the irritable condition of the skin of the thighs and legs. The face, hands and feet are free, but the condition of the forearms in point of severity and extent stands midway between the abdomen and lower extremities. The mucous membranes are not implicated.

Although to some extent ~~his~~ discomfort has been allayed and his subjective sensations lessened, yet it is but too obvious that the disease is gradually progressing and that it will eventually prove fatal.

Mycosis fungoides or Granuloma fungoides is stated to have been first described by Alibert in 1814 and later in 1832 and is figured among his illustrations of skin-diseases observed at the Hospital of St. Louis in Paris (Plate No. 36).

The disease has been observed by numerous authors since under a variety of synonyms, such as Eczema hypertrophicum vel tuberosum, Fibroma fungoides, Sarcomatosis generalis, Inflammatory fungoid neoplasm, Multiple sarcoma of skin, Lymphoderma perniciosum, Multiple fungoid papillomatous tumours, and Yaws.

By the last-mentioned name an admitted authority whom I knew personally, Dr. Gavin Milroy, in whose honour and memory the "Milroy Lectures" are delivered at the College of Physicians, described a case,* and later I had papers sent to me bearing upon

* *Med. Times and Gazette*, February 17, 1877, p. 169.

the disease by Dr., now Sir Henry Nicholls, an old fellow-student of mine, who is Medical Officer of Health for Dominica in the West Indies and Medical Superintendent of the Yaws Hospital. It is also certain that it has been erroneously regarded as a late stage of syphilis.

Mycosis fungoides has been recognised in this country comparatively recently.

We meet with two varieties of the disease, viz. :—

1. A form characterised by limited tumour-formation and preceded, sometimes for many years, by various more or less generalised scaly, papular, or erythematous disorder of the skin resembling eczema, lichen or urticaria associated with frequent and severe itching of agonising severity with burning and pricking sensations and insomnia.

Kaposi in 1887 advocated a subdivision of this group, drawing a distinction between

(a) Cases commencing with scaly eczematoid derangements and severe itching, and

(b) Cases in which the lesions are more like persistent urticaria followed by pigmentary changes suggesting sclerodermia and leprosy.

2. A form characterised by limited or extensive tumour-formation without any preceding surface disorder, the nodules and the disease running a more rapid and usually more fatal course.

Professor Paltau, of Vienna, has divided the disease into two classes as follows, viz. :—

1. The classic type, including varieties described by Kaposi and Besnier, preceded by skin-affections.

2. The type—*des tumeurs d'emblée*—not preceded by skin-affections.

He regards those cases accompanied by pseudo-leukæmia (lymphadenoma of English writers), described by Gillot, Landouzy, Galliard and others, as of importance in furnishing some support to the view that Mycosis fungoides is a *lymphadénie cutanéé*.

Whether these clinical differences result from different causes there is no evidence yet to prove, but it is certainly remarkable that while they both lead to fatal results—the latter more rapidly than the former—yet the evolution and course of the disease differ considerably in the two varieties.

My case just narrated may be accepted as a typical example of the

first variety. You noted that for a considerable period, for years in fact, he was treated for eczema, psoriasis, urticaria, and lupus in several parts of the country without any suspicion having existed in the minds of those who prescribed for him that he was the subject of the premycotic stage of *Mycosis fungoides*. Even now, more than ten years having elapsed, he has not developed true tumours, the thickened and infiltrated plaques only representing the areas of limited structural change.

A case is reported as having been treated by Hebra in the early stages as eczema, and Ziemssen in 1865 reported one in the person of a man aged 36 years who, at the age of 5 years, suffered a generalised papular eruption which became scaly. Fifteen years later it was regarded as ichthyosis, and when he was 32 years old the skin commenced to discharge and exhibit "broad, weeping, condylomatous patches."

Three months later he was practically covered with "fungating tumours of soft consistence and pink colour, secreting profusely. Some of them were three inches in diameter and elevated half an inch above the surface, others quite small. On the extensor surfaces of the extremities patches occurred having the appearance of psoriasis."

Kaposi wrote that "almost in all cases *Mycosis fungoides* begins with symptoms of eczema," and this has been borne out by later experience, although in some instances, as narrated, the early cutaneous changes may simulate erythema, psoriasis, urticaria, &c. The eruption may involve any part of the body as well as the face, neck and extremities, but the palms of the hands, and the soles of the feet generally escape. Thickening and infiltration follow, causing roundish patches hard to the touch, of varying degrees of red colour, which disappear and recur in or about the same area and leave more or less permanent pigmentary changes.

"The lesions are often circinate or gyrate in form and central atrophic depressions may follow. Orbicular patches with marked oedematous infiltration of the corium make the surface prominent, smooth and shining. Later nodular tumours usually develop which may undergo spontaneous involution, leaving the skin but little changed, or more or less pigmented, with a tendency to recur."

The tumours themselves vary in size, occasionally assuming very

large dimensions which, when persisting, undergo softening, exposing a bleeding base from which ichorous viscid and offensive discharges escape, probably followed by extensive ulceration. The glands are generally unaffected. At this juncture serious constitutional disturbances supervene accompanied by remittent or intermittent fever followed by marasmus, the so-called typhoid state, and death.

Concerning the relative frequency with which this disease is met with in the two sexes, Radcliffe-Crocker relates that Tilden found that in thirty cases twenty-three were males and seven females.

Twenty were over 30 years of age, the extremes being 20 and 68 years.

No two instances occurred in one family.

I have collected notes of twenty-eight marked cases and four of doubtful character, to which I will refer later.

Of the former twenty-eight cases, twenty-two were males and six females.

Twenty-two occurred over 30 years of age, and six under 30 years of age—the extremes being 25 and 72 years.

I have tabulated these as follows, viz. :—

MYCOSIS FUNGOIDES.

Table of Cases, thirty-one in number, published during the last ten years.

1. Russian, female, aged 48 years.—Tumour-formation concomitant with eczematous and erysipelatous outbreaks, new growths from the very beginning. Some of the earlier ones completely disappeared. Died fifteen months after onset. Reported by Drs. Stelwagon and Hatch.

2. Male, aged 89.—Tumours appeared twelve years after onset. Died thirteen years after onset. Reported by Drs. Stelwagon and Hatch.

3. Male, aged 66.—Tumours one year after onset. Died fifteen months after onset. Reported by Dr. Pye-Smith.

4. Female, aged 52.—Tumours fifteen months after onset. Result? Reported by Dr. Hallopeau.

5. Male, aged 72.—Progressive gangrene of palate, and almost universal induration of skin followed. Result? Reported by Dr. Hallopeau.

6. Male, aged 50.—Tumours three years after onset. Died four and a half years after onset. Reported by Dr. Fox.

7. Male, aged?—Suffered for thirty-five years. Result? Reported by Dr. Stopford Taylor.

8. Male, aged 28. Unusual case? Mycosis fungoides. Died of exhaustion. Reported by Mr. J. Hutchinson, junior.

9. Female, aged 45.—Tumours appeared four or five years after onset. Result? Reported by Dr. Leslie Roberts.

10. Male, aged 49.—First tumour two years after commencement of eruption, followed by others. Duration of disease when seen, nine years. Result? Reported by Dr. T. C. Fox.

11. —, —.—Very little general eruption, with numerous tumours. Growths developed in the larynx. Reported by Dr. de Havilland Hall.

12. —, —.—Very few tumours, but body universally affected by eczematoid eruption. Reported by Dr. T. C. Fox.

13. —, —.—Ten years' duration. Skin exhibited general eczematous condition and numerous tumours in various stages of evolution and involution. Result? Reported by Dr. T. C. Fox.

14. Male, aged 42.—Disease following long persistent eczematoid affection of the skin. Result? Reported by Dr. Stephen Mackenzie.

15. Male, aged 26.—Had had tumours for three years before seen. Result? Reported by Dr. Pye-Smith.

16. Male, aged 59.—“Aberrant form.” Reported by Dr. Pye-Smith.

17. Male, aged 85.—Had a tumour, followed by dermatitis of wide distribution. Died of pneumonia.

18. Male, aged 71.—Died of exhaustion. Reported by Dr. Dubreuilh.

19. Male, aged 65.—Tumours five months after onset. Result? Reported by Dr. Radcliffe-Crocker.

20. Male, aged 25.—Nodular growth under each lower eyelid, similar lesions near left nostril and under right ear. Diagnosis doubtful. Reported by Dr. Radcliffe-Crocker.

21. Male, aged 53.—Had been twenty-six years in India. Reported by Mr. Malcolm Morris.

22. Male, aged 54.—Tumours eight years after onset. Reported by Dr. P. Morrow.

23. Female, aged 86.—Tumours ten years after onset. Reported by Dr. P. Morrow.

24. Male, aged 64.—Tumour formation not marked. Typhoid state supervened, but left hospital. Result? Reported by Dr. A. Whitfield.

25. Male, aged 70. Two years' duration. Shown at Edinburgh Meeting of British Medical Association, 1898, by Dr. Macdonald.

26. Female, aged 57.—Very remarkable case. Reported by Mr. A. Carless.

27. Female, aged 45.—Died eleven months after onset. Reported by Mr. Swinford Edwards.

28. Female, aged 26.—Five years' duration. Reported by Mr. J. Hutchinson, junior.

29. Male, aged 25.—Duration four years. Premycotic stage. Reported by Dr. E. C. Perry.

30. Male, aged 56.—Duration four years. Reported by Dr. P. S. Abraham.

31. Male, aged 27.—Duration eleven years. Still living. Reported by J. H. Stowers.

To several of these I would like to draw further attention on account of the special features which characterised them.

In Case I. it was noted that the whole disorder was "made up of a medley of what at different times might be looked upon as eczema, erysipelas, leprosy patches, and new growths. Itching and burning were of variable intensity." *

Case II. is remarkable on account of the very numerous growths (500 to 600) which developed, several showing marked pedunculation.†

Case III., that reported by Dr. Pye-Smith, is very important. The patient, a male, aged 66 years, had recurrent dermatitis of eczematous nature. One year after this localised swellings commenced which slowly developed and proceeded to suppuration. Exuberant granulations followed, accompanied by much discharge of a clear, colourless, alkaline, albuminous character. Some of the tumours suppurated and healed. The general health failed suddenly, accompanied by delirium. Hæmorrhagic pustular eruptions appeared together with redness and swelling simulating erysipelas, and death ensued about fifteen months after the commencement of the disease.

A detailed‡ post-mortem examination was made with the following result, viz. :—"A large white tumour was found in the left adrenal. Microscopically the skin-tumours consisted of leucocytes, small and uniform in appearance with very scanty intercellular stroma."

The adrenal tumour "presented a similar appearance, but some sections had better developed and more abundant intercellular fibrous tissue, so as to resemble lymphoma, and others might be fairly described as showing the structure of a small round-celled sarcoma. No micro-organisms could be detected during life, or after death."

Case V., male, aged 72 years, under the care of Dr. Hallopeau,§ was marked by almost universal induration of the skin, and accompanied by a serious phase of the disease occasionally met with—viz., progressive gangrene of the palate, &c. The pruritus was very violent and persistent. It was suggested that the gangrenous process was probably caused by the obliteration of small blood-vessels.

* *Journ. of Cut. and Gen.-Urin. Dis.*, January, 1892.

† *Journ. of Cut. and Gen.-Urin. Dis.*, February, 1892.

‡ *Clin. Soc.'s Trans.*, Vol. XXV., 1892.

§ *Journ. Mal. Cut. et Syph.*, Vol. V., 1893, p. 150.

Case VII., a male, whose age is not mentioned, suffered from the disease for the unusually long period of 35 years.*

Case VIII. is marked with a note of interrogation as there appeared some doubt in the diagnosis,† but the face of the patient, a male, aged 28 years, was described as “leonine,” an aspect not uncommon in severe and fatal Mycosis fungoides. In this instance also a “general enlargement of the lymphatic glands supervened,” which, although unusual, still has been reported in other cases of undoubted character.

Case IX., a female, aged 45 years (reported by Dr. Leslie Roberts),‡ suffered four or five years before admission into hospital, a “moist pruritic eruption on the left arm which remained a few months, and disappeared spontaneously.” This reappeared at intervals, and subsequently the whole cutaneous surface became involved. Large tumours developed upon the face.

Case X.§ commenced as an eczematoid eruption on the scalp, trunk and limbs which lasted nine years. The first tumour developed two years after the onset of the disease, and was followed by others of a like nature, some of which resolved spontaneously. The patient was a male, 49 years of age.

Case XI.|| In this, tumours occurred in the larynx.

Case XIV. A male, aged 42 years. Following long, persistent eczematoid affection of the skin. Serpiginous tuberculo-squamous lesions appeared generally over the body, which underwent ulceration, producing ulcers with unhealthy granulating bases.¶

Case XV. was exhibited at this Society by Dr. Pye-Smith on the 22nd of January, 1896. The patient, a male, aged 26 years, a farm labourer, had for three years had numerous tumours, some pedunculated. Several suppurated and sloughed, a few disappearing spontaneously. It was noted that in this case “the dermatitis appeared to be secondary.”

The exhibitor considered that the original disease was a granuloma, but that the secondary growth was a small-celled sarcoma.

* *Brit. Journ. of Derm.*, Vol. VI., 1894, p. 282.

† *Brit. Journ. of Derm.*, Vol. VII., 1895, p. 69.

‡ *Brit. Journ. of Derm.*, Vol. VII., 1895, p. 142.

§ *Brit. Journ. of Derm.*, Vol. VII., 1895, p. 213.

|| *Clin Soc.'s Trans.*

¶ *Brit. Journ. of Derm.*, Vol. VIII., 1896, p. 16.

The lymph-glands were unaffected.

Case XVI., also reported by Dr. Pye-Smith,* was that of a male patient, 59 years of age, who suffered what was described as an "aberrant form of Mycosis fungoides," the late Mr. Davies-Colley having five years previously removed a sarcomatous tumour situated over one scapula.

Case XVIII. is reported by Dr. Dubreuilh.† His patient, a male, aged 71 years, had for several years vague sensations of itching before any eruption appeared. Then various crusted and scaly patches ensued, and subsequently tumours developed, a few undergoing spontaneous involution. Later more extensive dermatitis and pigmentations followed, with remissions of disease, cachexia, diarrhoea, toxic fever, marasmus and death.

Case XIX., reported by Dr. Radcliffe-Crocker,‡ was that of a male, aged 65 years, in whom the disease had existed for five months.

"Numerous red thickened plaques were visible on the face, and one fungating tumour $1\frac{1}{2}$ inch in diameter. On the trunk, about twenty deep red nodules, and on the left thigh a tumour as large as a hen's egg, raised more than an inch above the surface. In addition to the above numerous patches of new growth of pale red colour and made up of close aggregation of minute acuminate papules with horny centres, chiefly on the buttocks and limbs, and appeared as if they were the first link in the chain of development."

Case XXI. was under the care of Mr. Malcolm Morris.§ The patient, a male, aged 53 years, had been twenty-six years in India.

"In 1886 a red swollen patch appeared on the outer and posterior part of left thigh. This ulcerated, discharged and healed. Five years later another tumour developed on left side of chest. This ulcerated and healed. In November, 1897 (when the case was exhibited at the Dermatological Society of London), raised reddish blotches, fading on pressure, were visible on the scalp.

"Upper arms numerous ulcerating patches.

"On the right forearm two ulcerated patches $2\frac{1}{4}$ by $1\frac{1}{2}$ inches in diameter.

* *Brit. Journ. of Derm.*, Vol VIII., 1896, p. 861.

† *Journ. de Médecine de Bordeaux*, June 16th, 1895.

‡ *Brit. Journ. of Derm.*, Vol. IX., 1897.

§ *Brit. Journ. of Derm.*, Vol. IX., 1897, p. 478.

“ On the left forearm irregular nodular patches, but not ulcerated.

“ Chest, back, scrotum and legs also affected.

“ Soles and palms free.

“ Burning and itching associated with the disease.”

Case XXII., reported by Dr. P. A. Morrow.* Patient, a male, aged 54 years. First seen in 1894, with a history of seven years' suffering from “scattered, reddish, slightly scaly eczematoid blotches. The patches assumed a brownish colour, exuded and crusted. On the left thigh a patch existed which was roughened with nodular elevations. Itching slight.”

The course of the disease was marked by periods of activity alternating with periods of repose. A progressive thickening and tumefaction of certain areas followed by eventual fungating and ulcerated lesions. Palms and soles free.

The first distinct tumour developed eight years after commencement of disease.

Case XXIII., also reported by Morrow, was that of a female aged 36 years. Numerous red patches developed six years before, accompanied by intense itching.

The right arm was first affected above the elbow. The eruption spread and was followed by a similar outbreak on the right leg. Four years later tumours developed. Several disappeared spontaneously, but were followed by a ‘rapid evolution of eruption and progression’ of the disease.”

The eruption had a circinate appearance in places.

Case XXIV. was described in detail by Dr. Whitfield,† and published with excellent illustrations. His patient was a male, aged 64 years. A generalised eruption of desquamative character existed prior to the formation of tumours, which were but slightly marked. The skin of the face bore the appearance of chronic eczema, also the scalp. Upon the latter small nodules developed, some grouped with greasy scales upon the surface. Six large ulcers existed upon different parts of the body. The patient fell into a low typhoid state, but, being removed from hospital, the termination of the case is not recorded.

* *Journ. of Cut. and Gen.-Urin. Dis.*, Vol. XIV., No. 171, 1896, with illustrations.

† *Brit. Journ. of Derm.*, Vol. X., 1898, p. 152.

Case XXVI. had a remarkable history. The patient, a female, aged 57 years, developed during her first pregnancy an "eczematous eruption" upon the labia. A similar eruption developed during the third pregnancy, and again with each succeeding pregnancy, eleven in all. Later a severe desquamative dermatitis ensued of more general distribution. "Some years afterwards lumps appeared on the lower extremities, and rounded tumours on the thighs, which ulcerated," together with "extensive ulceration of gums, under tongue, on tonsils and buccal mucous membrane, the pharynx becoming involved."

This patient was exhibited by Mr. Albert Carless at the Dermatological Society of London in July, 1898.

Case XXVII. was that of a female, aged 45 years, under the care of Mr. Swinford Edwards* in 1885. It was the first of the kind that I and others had seen, and no conclusive diagnosis was arrived at during the life of the patient. The history was remarkable in several particulars, the disease developing very rapidly and proving fatal in about eleven months from the date of onset. The patient was stated to have been quite well ten months before admission into hospital. The report includes the following:—"Ten days after confinement she noticed a small pimple on the inner aspect of the right thigh. Over the inner part of Scarpa's triangle on the right side, and extending downwards to the junction of the lower with the middle third on the inner aspect of the thigh, was a raw surface of a bright red colour glistening and somewhat raised. The skin around was pigmented, and the subjacent tissues indurated. Adjoining were several nodules of various sizes of different stages of development, some subcutaneous and of a darker colour than the surrounding parts, others raised and covered with a scab, whilst others again had ulcerated, presenting a remarkably circular circumference, depressed saucer-like centre, and indurated base.

"On the lower part of the abdomen over the hypogastrium and right iliac region were a few ill-defined spots of a papular nature, which showed signs of breaking down. There was no discharge or foetor from the large sore on the thigh, which had evidently been formed by the coalescence of many nodules, and had this peculiarity,

* Published in detail as a case of "Round-celled Sarcoma of the Skin," *Trans. Patholog. Society*, 1885, p. 468.

that although forming one mass, each nodule retained its distinct and accurately circular outline."

The patient had been married twenty-five years, and had had eleven children. She died twenty-three days after admission in a typhoid state, acute diarrhoea having existed for several days.

A post-mortem examination was made, and the following is the result of a microscopic investigation undertaken by Dr. Klein:—He reported that "the material had been carefully examined, and as far as the microscopic appearances went he should certainly pronounce it a round-celled sarcoma."

I fear that I have wearied you by narrating so many instances of this important disease, but I have done so chiefly because, owing to its rarity, some of our members have had but little, if any, opportunity of observing it.

Again, by reviewing the group, we shall learn that, however much individual cases vary in their circumstances and detail, there is no small degree of similarity between the varieties of the disorder—viz., those in which recurrent or persistent forms of dermatitis, simulating other disorders, occur, followed, perhaps, after many years of suffering by the development of nodules and ultimately proving fatal; and, secondly, those characterised by the early or immediate evolution of tumours which undergo secondary changes, terminating in death more rapidly than in the first variety.

The cause of Mycosis fungoides has yet to be discovered. It is certain, however, that the prodromal eruptions constitute part of the disease proper, and are not merely manifestations of the simpler disorders which they simulate, and for which they are so frequently mistaken.

Drs. Hyde and Montgomery* summarise the three hypotheses as to the nature of the condition as follows, viz. :—(1) That the disease belongs to the class Sarcomata. (2) That it is one of the infective granulomata. (3) That it is a disease commencing with a primary lesion with evolution of symptoms in definite stages analagous to those of syphilis, one or more of which may be at times suppressed. And they add, that "the facts point to a systemic origin for Mycosis fungoides as definitely and unmistakably as a glycosuric xanthoma

* *Journ. of Cut. and Gen.-Urin. Dis.*, Vol. XVII., p. 253, June, 1899.

points to a condition which could by no possibility have been explained by an examination merely of its cutaneous lesions."

Referring again to Cases III. and XXVII. (those reported by Dr. Pye-Smith and Mr. Swinford Edwards respectively), we have two well-marked instances of the disease in which the independent microscopic examinations proved the existence of cells indistinguishable from those of a round-celled sarcoma, although in the former some part of the adrenal tumour resembled a lymphoma.

Some observers have described the minute structure of the tumours as a lympho-sarcoma while others have urged that the nodules are the result of a chronic inflammatory process and are of the nature of a granuloma.

Dr. Payne* has recorded that he has seen a case having the clinical appearances of Mycosis fungoides while the tumours had a spindle-celled sarcoma character.

The hypothesis that the disease belongs to the class Sarcomata does not account, however, for the spontaneous diminution or disappearance of the new growths which so frequently occurs in the course of the disease.

Again, the characters of a lympho-sarcoma are not sufficiently constant to explain its pathology.

The inflammatory type also of some of the cells and their nuclei is not strictly that of sarcoma. Payne concludes that, "it is best, therefore, to regard the growth provisionally as a chronic inflammatory neoplasm or granuloma dependent upon some local irritant as yet undiscovered."

Kaposi, dissatisfied with the various hypotheses, preferred to regard Mycosis fungoides as a disease *sui generis*, it being neither contagious nor hereditary.

Various micro-organisms have been reported as existing in the tissues, but none have been proved to be essential to the disease, and in numerous cases examinations of the blood have been attended with negative results. In the *Glasgow Hospital Reports*, for 1898, Drs. McVail, Murray, and Atkinson report that they succeeded in isolating a bacillus in a case which when injected into rabbits was followed by pathological changes and death.

* "Allbutt's System of Medicine," Vol. VIII., p. 885.

But these observations require corroboration before their conclusions can be finally accepted.

The most recent investigations of the morbid structure of the disease in this country with which I am familiar have been carried out by Drs. James Galloway and J. M. H. MacLeod, and are published *in extenso* in the *British Journal of Dermatology* for May and June, 1900.

They examined three cases, the clinical features of which they describe at length. The two first were those of married women, aged 47 and 32 years respectively, and the third was that of a male subject, aged 42 years.

The authors state "that the cellular infiltration which is so abundantly present in all our preparations resembles far more closely that presented by the infective granulomata than that shown by any of the true neoplasms. And it is in the class of the infective granulomata that we consider Mycosis fungoides should be placed."

They then confirm the observations that the initial change is first seen in the corium, and that the characteristic cellular infiltration occurs primarily in the sub-papillary layer of the cutis and spreads. After noticing that this infiltration is visible around the blood-vessels, hair-follicles, and sebaceous glands, &c., and also independently in the lymphatic spaces, they point out "that the infiltration though seen early in the neighbourhood of the blood-vessels, does not necessarily arise in connection with them." (*Vide* coloured Illustrations and Plates.)

An interesting and exhaustive bacteriological examination of the cases was made by Dr. J. W. H. Eyre, and is included in the report. In it he states that the bacillus of Friedländer has no proved connection with Mycosis fungoides; and also that he failed to observe a bacillus similar to that described in the *Glasgow Hospital Reports*, to which I have alluded.

Finally, Drs. Galloway and MacLeod agree that Mycosis fungoides is histologically distinct from the class Sarcomata.

I must refer you to this very able research, which is described in detail, occupying many pages of the journal, and ask you to study it closely.

On the subject of treatment I will not detain you, suffice it to say

that at present no reliable method is known with which to combat successfully this terrible disease.

It is sincerely to be hoped, however, that as we learn more concerning its nature, we may discover the means both of prevention and cure.

Before I conclude, I must briefly express the sentiments which do not exist in our minds alone, but in the minds and hearts of the whole profession in this and every other nation and empire of the world, called up by the recent loss sustained by the death of that great master of science, Professor Rudolf Virchow.

It may be that some of you will remember him in London during the Medical Congress in 1881. And again more recently in 1898, when he delivered the "Huxley Lecture" at the Charing Cross Medical School on "Recent Advances in Physiology." I was privileged to be present on each occasion and to hear his words of truth and wisdom.

As expressed by the Sovereign Ruler of his country, another "great investigator, healer, and teacher, whose life-work opened up new channels for medical science," has passed away.

While deploring his loss we must be deeply grateful that humanity has benefited, and will ever benefit, by the results of his labours.

His brilliant example will remain to stimulate and encourage the true spirit of science both here and throughout the world, and especially among those who, like ourselves, are striving—however humbly—to lighten the load of the heavy laden.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of this Society was held on Wednesday, January 14th, 1908, Dr. RADCLIFFE-CROCKER in the Chair.

The following cases and specimens were demonstrated :—

Dr. EWART (introduced by Dr. PENROSE) demonstrated some coloured lantern-slide photographs and read the notes of a case of *purpuric Eruption*, the patient being too ill to come before the

Society. The patient was a butler, aged 30, of regular habits and healthy antecedents. He was seized on December 24th, 1902, with sore throat, trembling and chilliness, though without definite rigor. On the 26th he took to his bed, and on the 28th the sore throat left him, but the left side of his face swelled up. He was admitted to St. George's Hospital on December 30th, suffering from typical facial erysipelas. Full doses of perchloride of iron were ordered, but as no improvement took place an alkaline mixture was substituted, and frequent doses of quinine were given. Under this treatment the patient improved rapidly, the temperature coming down to 99° on January 3rd, and never rising again to any great height. On the evening of January 3rd, when the first purpuric symptoms were noticed, he had had twenty grains of quinine, and the total amount taken when it was stopped on January 5th was forty grains. The early eruption consisted of small dark purple patches with raised, pink and intensely tender areolæ. The earliest sites to be attacked were the lower extremities, but on the second day the eruption had crept up on to the trunk. Much larger patches were soon formed, partly by coalescence of smaller ones, and the eruption spread on to the back of the thorax and the outer aspects of the upper arms. There was also a patch on the occipital region, and there was oedema of the conjunctiva with subsequent flow of blood-stained tears.

The characteristics of the rash were:—(1) Its occurrence in circular patches. (2) The raised and extremely tender, pink areolæ. (3) The gradual disappearance of the purple centre, which became lighter than the periphery. (4) The occurrence after a few days of considerable oedema of the conjunctivæ, arms, legs, back and thighs. (5) The obvious localisation at the points of pressure. (6) The formation of bullæ, which necrosed and left superficial ulcers.

As regards the causation of the rash, considerable interest was attached to it owing to the fact that the patient had been taking large doses of quinine, but it was of course impossible to determine at once whether it was the result of the quinine intoxication or

the Society, the patient, who had nearly been treated with large doses of quinine, but no rash had taken place.

Dr. J. M. H. MacLEOD showed a case of *Alopecia areata*, of a rapidly spreading disseminated type. The patient was a little girl, aged 6 years, in apparently good health. She presented a general thinning of the hair, like the defluvium which may occur in association with scarlet fever, but added to this there were several variously sized irregular bald patches. The falling out of the hair was first noticed by the mother three weeks ago, and in this short time more than half of the hair had been shed. On examination of the scalp, the characteristic clavate stumps of *Alopecia areata* were found in large numbers, as well as split hairs, hairs with brush ends, and various other types of atrophic stumps. In the bald areas the skin was not smooth and glossy, but presented a yellowish pink tinge, and was dotted over with plugged follicles and felt almost like goose-skin. A microscopical examination of a number of the stumps proved them to be typical atrophic hairs of *Alopecia areata*, but staining of them for micro-organisms was followed by negative results.

The child seemed to be in good general health. Her skin had been previously healthy, with the exception of her scalp, which had always been scurfy, and as far as the mother was aware the skin of the face had never presented any dry scaly patches of eczema. There were five other children; none of them had *Alopecia areata*, eczema of the face, or scurfy scalps.

The case was of special interest, owing to the rapidity with which the disease had spread, and the disseminated nature of it. It conformed to neither of Sabouraud's types, for it could not be classed either as an example of the "patchy type," where the lesions closely simulate in their distribution those of microsporon ringworm, or of the "band type," or "ophiasis." Still the plugging of the follicles and the slight congestion around them, and the association of the condition with a scurfy state of the scalp all brought it into line with the patchy type of the disease, which Sabouraud regards as an acute local seborrhœa capitis. Though a parasitic cause had not been definitely established in these cases, yet it seemed more reasonable to look forward to such being found than to attempt to explain their ætiology as the result of general nervous shock or injury to cutaneous nerves.

Dr. RADCLIFFE-CROCKER showed a private patient for diagnosis.

He was a well-to-do butcher, aged 56, with a good family history, the father having lived to the age of 86 and his mother to 74. He first noticed the eruption at the end of November, but it may have been there longer, as there was scarcely any itching or other sensory symptom, and as he gets up at four o'clock, he does not examine his skin very often. He had syphilis in 1879, and was well treated for two years, and has had no recurrence. The main patches of eruption are symmetrical on each side in the line and direction of the lower ribs, and consist of erythematous compound patches about 3 inches long and 2 inches broad, and a separate smaller patch in the same direction anterior to it. The surface is very faintly roughened when examined with a lens, the border is well defined, and when the patch is pinched up it is distinctly thickened, though it is rather less than when he first came under treatment. There are other patches of the same general characters, but less marked and not symmetrical, over the left shoulder, on the sides above the larger patches, on the back of the forearms, and on the right arm. There had been very little, if any, change from the time he had first noticed them, and none had gone away. He was a stout, ruddy, healthy-looking man, stood 5 feet 8 inches, and weighed 14 stones 7 pounds.

Nearly all the members of the Society and Dr. Montgomery, of Chicago, who was present as a visitor, declined to make a positive diagnosis, though the possibility of its being an early stage of *Mycosis fungoides* occurred to many. The exhibitor was strongly of opinion that they were premycotic lesions, as he knew of no alternative disease which would present infiltrating lesions with the characters here shown.

Dr. WHITFIELD exhibited a little boy, aged 3, suffering with ordinary *microsporon of the scalp* which had been treated by X-rays. There were two patches of the disease present, one on each parietal eminence. The whole head was put under a weak oleate of mercury ointment to guard against any spread of the eruption, and one patch was treated at a time. Exposures of ten minutes to a moderately high tube were given with about four inches interval between the child's head and the anticathode. The treatment was commenced on November 26th, 1902, and from that date to December 16th, fourteen exposures were given. It was then noticed that a slight blush was

present, and the hair seemed to be loosening. Treatment was therefore stopped, and in the following week a rapid shedding of the hair took place, the sound hairs coming away before the stumps. This was probably owing to their greater length and rigidity which caused them to be rubbed out. Examination of the loose stumps showed them to have a completely cornified and pointed root such as one sees in some cases of Alopecia areata. By December 30th the patch was completely bald and pale, and was apparently cured. The treatment of the other patch was accordingly commenced on December 31st, and up to the date of the meeting, ten exposures had been given, with the result that when shown it was of a faint pink colour, though not more than is often seen in uncomplicated microsporon of fair and young children. The hair on the patch first treated was just beginning to show itself again in the shape of fine and healthy down.

Dr. Whitfield said that it was, of course, too early to speak positively of the method of treatment, but he thought it gave great promise. One or two cases under his care had now been treated, and the results had been excellent, and he had not had any difficulty with regard to the return of the hair. A case of favus had done very well for a time, but the patient was careless, and as the disease affected the whole scalp and necessitated the removal of the hair in patches, and he had absented himself for long periods, he had allowed his new hair to become infected from the parts of the scalp not treated. Finally he was lost sight of entirely.

Personally Dr. Whitfield believed the method to be quite safe in skilled hands, provided that fairly high tubes were used, and the current was not increased if the hair did not fall quickly. He said that it was apparently more clean, painless and efficient than the other methods, but it required a little more experience before adopting it as a routine method. Also he pointed out that for scattered isolated stumps the method of needling with croton oil would still hold its place. He would like to draw the members' attention to the report of cases treated by Gastou, Vieira and Nicolau in the November number of the *Annales de Dermatologie*.

Dr. Colcott Fox said that he agreed that the result was very satisfactory in this case, but that in a case of favus treated for him by the X-rays the hair had fallen out, and several months afterwards had not returned.

Dr. Radcliffe-Crocker said that some observers recommended the use of very low tubes, and yet had no burning.

Dr. S. E. DORE said that in his experience much depended on the strength of current used. If one used a low tube one could get plenty of active rays with a very small current, and he did not think the results more severe than in the case of a high tube where one had to use much stronger currents to get anything through the tube. Of course, if one were used to employing strong currents and high tubes, and then used the same currents with a low tube, burning would probably ensue.

Dr. WHITFIELD, in reply, said that he quite agreed with the statement of Dr. Dore, but he believed that it was the general opinion that the effects of high tubes were more immediate, and those of low tubes rather delayed. Under these circumstances he thought it safer and infinitely more convenient to use moderately high tubes.

"THE JOURNAL OF CUTANEOUS DISEASES."

CHANGE OF MANAGEMENT.

WITH the number for January, 1903, the *Journal of Cutaneous and Genito-Urinary Diseases* commences its twenty-first volume under entirely new auspices and with the above new title. Dr. J. C. Johnston, the acting editor, in association with Dr. G. K. Swinburne and Dr. Boleslaw Lapowski, have been responsible for the journal since 1897. These gentlemen no longer control the journal. In saying farewell to the old management in their editorial capacity, we wish to assure its members of our appreciation of the vigour with which they have carried on the work of the American journal.

Dr. Johnston has been for long personally known to us, and has at all times been a valued colleague. We have no doubt that his interest in the American journal under the new conditions will not suffer diminution, though he may rejoice in his freedom from responsibility. The difficulties in conducting a special journal devoted to Dermatology, some of which he mentions in the farewell letter in his December number, we fully appreciate; but everyone can see how faithfully Dr. Johnston and his colleagues have attempted to combine the two different departments of medicine hitherto represented by their journal.

The change just come about has long been rumoured. The journal will now be under the editorial management of Drs. James C. White and John T. Bowen, of Boston, Dr. James Nevins Hyde, of Chicago,

Dr. Henry Stelwagon, of Philadelphia, Drs. Prince A. Morrow, Edward B. Bronson, George T. Jackson and John A. Fordyce, of New York. Dr. A. E. Mewborn, of New York—to whom we convey our best wishes—will be the acting editor. The journal will in future deal with the subjects of Dermatology and Syphilology only, and has the advantage of becoming the official organ of the American Dermatological Association.

This is a step in the normal process of development, and there can be no doubt that the American journal will increase in interest and usefulness.

REVIEWS.

TRANSACTIONS OF THE AMERICAN DERMATOLOGICAL ASSOCIATION.*

THE official report of the Annual Meeting of the American Dermatological Association gives strong evidence of the earnest work which this Society is doing for dermatology. It will only be possible here to refer briefly to a few of the leading communications at this interesting meeting. The presidential address was delivered by Dr. Shepherd, of Montreal. The President referred to the advances in dermatology during the century; to the researches of Schönlein and Gruby; to the influence of the work of Pasteur, Lister, and Koch on it; and traced the history of dermatology from the time of Plenck, Willan, and Bateman down to the present day.

The first paper was read by Dr. Douglass Montgomery, of San Francisco, on the *Cause of Streaks in Nævus Linearis*. A suggestive case was cited, a report of which has already appeared in the *Journ. of Cut. and Gen.-Urin. Dis.*, October, 1901. An interesting discussion followed the reading of the paper. The next contribution was a paper by Dr. Charles Allen on *Lichen Planus as a Vesicular and Bullous Affection*, in which two cases of vesiculo-bullous Lichen planus were reported and the literature on the subject considered. Dr. Johnston read his paper on *Sarcoma and the Sarcoid Growths of the Skin*, which was published in full in the *Brit. Journ. of Derm.*, 1901, XIII., p. 241. An important communication on a *Case of Lymphatic Leukæmia, Apparently Developing out of Hodgkin's Disease, Accompanied by Leukæmic Lesions and Pigmentation of the Skin, Culminating in Streptococcus Infection*, was made by Dr. Wende, of Buffalo. In it lymphomata developed in the skin. The presence of Hodgkin's disease was demonstrated both by the physical signs and the characteristic changes in the blood. The tumours showed a tendency to spontaneous increase and diminution. The changes in the blood underwent a transition from those of pseudoleukæmia into those of true lymphatic leukæmia. The lymphatic leukæmia then disappeared, and the patient died of general septicæmia. An excellent photograph of

* *Transactions of the American Dermatological Association at its Twenty-fifth Annual Meeting, May, 1901. Official Report of the Proceedings by F. H. Montgomery. (Rooney and Otten Printing Co., New York.)*

the patient, a man aged 28 years, illustrates the paper, and shows the presence of tumours on the chest, abdomen, and one on the left temple. Remarking on the case, Dr. Johnston said that he considered it to be about the only one of undeniable lymphatic leukæmia of the skin which had ever been reported. Dr. Shepherd read a paper on *Two Cases of Blastomycetic Dermatitis, one of which was Cured by Iodide of Potassium*, and Drs. Montgomery and Walker presented a further report of a previously recorded case of *Blastomycosis of the Skin*, in which a systemic infection with blastomyces took place which resulted in death. On the morning session of the second day of the meeting a general discussion on the *Diseases of the Nail* was opened by a series of papers on the Parasitic diseases, by Dr. Grindon; the Inflammatory diseases, by Dr. Pollitzer; the Trophic diseases, by Dr. Zeisler; and the Treatment of Nail-affections, by Dr. Hardaway. The discussion was well sustained, and the account of it is singularly instructive. Dr. Bronson, of New York, read a short practical paper on the *Treatment of Certain Deep-seated or Rebellious Forms of Disease of the Follicles, More Particularly by Intrafollicular Methods*, and advocated the combined treatment by "exfoliation with resorcin and electrolysis employed alternately at such intervals as the case may require." An extraordinary case of *Quinine Susceptibility* was reported by Dr. Stelwagon, of Philadelphia, in an adult, in which the smallest dose of quinine, even one-eighth of a grain, was sufficient to cause a profuse scarlatiniform eruption, followed by desquamation. Dr. White, of Boston, presented a communication on *Colloid Degeneration of the Skin*, which appeared in the *Journ. of Cut. and Gen.-Urin. Dis.*, February, 1902, and Dr. Ravogli a paper on *Multiple Nodular Melano-Carcinoma of the Skin from a Nævus*, which was published in June, 1901, in the same Journal. Dr. Pusey, of Chicago, contributed a paper on *Röntgen Rays in the Treatment of Diseases of the Skin*, in which satisfactory results were reported in the treatment of Hypertrichosis, Acne, Sycosis, Lupus vulgaris, and Carcinoma. He employs repeated exposures to a weak light, the effect of which may be controlled, and the treatment is interrupted at the first indication of reaction. He believes that the beneficial effect of the rays is due to a stimulation of the tissue rather than to any bactericidal action, and considers that the essential factor is something in the rays themselves, and not some incident of their production like ozone or brush-discharges, or induced electrical currents in the tissues. He even goes so far as to believe that the active rays among the X-rays are "identical, or at least so similar in all of their properties as to be practically identical, with the rays at and beyond the violet end of the spectrum. If this is true this method of treatment is identical in principle with that of Finsen."

The third day of the meeting was devoted to the demonstration of cases, and of these, cases of Ainhum and Blastomycosis were among the rarities. This short account of the meeting will serve to show the vast amount of excellent work that is being done in the subject on the other side of the Atlantic.

J. M. H. M.

A TREATISE ON DISEASES OF THE SKIN.*

THE Diseases of the Skin by Stelwagon adds yet another to the steadily increasing number of American text-books on dermatology. It is refreshing to

* *A Treatise on Diseases of the Skin.* By Henry W. Stelwagon. (W. B. Saunders & Co., Philadelphia and London. Price 25s.)

find that in this one there is nothing of the nature of the smaller American publications on the subject, nothing suggestive of what is known as a "quiz compend," but rather a careful, reliable text-book which will be of value not only to the practitioners and students of dermatology in America, but to the whole dermatological world. The treatise makes no profession of marked originality, but it is thoroughly up-to-date and, in our opinion, sound. The treatment of the subject is eminently practical, and special attention is paid to the all-important subjects of diagnosis and treatment, not, however, to the exclusion of the pathology of the skin, for the latter subject is adequately dealt with and the references to the recent literature on it are exceptionally complete.

The classification adopted is that of Hebra as modified by Crocker. The introductory chapters on the anatomy, physiology and general symptomatology are more than usually adequate, and that on the general diagnosis is sensible, practical, and emphasizes a number of commonplaces which are far too often lost sight of in the diagnosing of obscure forms of dermatitis. It is the privilege of the critic to pick faults, and several trivial blemishes strike us, but these are of such secondary importance as to in no way depreciate the value of the book. In a future edition we might suggest that the three pages on general configuration should be once and for all purged of the formidable array of dog-Latin adjectives which have done so much to make the terminology of dermatology confusing; there does not seem to be any gain in placing the Latin equivalent in brackets after translating it, or in the employment of such ugly words as *scutiformis*, *neuriticus* and the like. And what is to become of the English language! Is it to become a language of monosyllables? Why clip the "al" off such words as *histological*? *Myxedema* and *frambesia* are unattractive spellings and *monilethrix* is incorrect.

The work reaches over 1,000 pages; it is well printed, but, like other American publications, on shiny paper, which we always find difficult to read by artificial light. It is excellently illustrated, having over 200 illustrations in the text and twenty-six full-page lithographic and half-tone plates. The illustrations are chiefly in the nature of reproductions of photographs of patients. Several of them are familiar. There are also impressions of a number of the blocks showing histological changes in the tissues which we have seen already in *Duhring's* text-book. The lithographic plates are borrowed from *Mracek's Atlas*.

On the whole it is an excellent text-book on dermatology, and we congratulate Dr. Stelwagon most heartily on the result of his work.

DIE BLASTOMYKOSE.*

We owe to Professor Neisser and to Dr. Buschke this excellent number, which makes the tenth publication in the section of Dermatology and Syphilis of the well-known series of monographs, appearing in the "*Bibliotheca Medica*." The initiative and constant support which Professor Neisser has given to the interests of Dermatology earns him the best thanks of his colleagues, and not the least important of his enterprises is the publication of the series of monographs alluded to. Dr. Buschke's interest in the subject of blastomycosis is well-known to pathologists on account of his own publications on the subject, and also on account of the interest taken in the work of other investigators. The greater part of the present monograph was ready for publication in June, 1899. For various reasons,

* *Die Blastomykose*. By A. Buschke. ("*Bibliotheca Medica*.")

tion of the follicles which in kerion are the chief seats of the disease. The deeper colour of the granuloma, its greater elevation, and the much greater duration of the tumour form further points of difference which scarcely admit of confusion. Also kerion empties itself by means of the follicles, while the granuloma, after lasting a considerable time, softens and opens like an abscess. The histology showed a mass of detritus consisting chiefly of broken-down epithelial cells, blood and leucocytes in the softened parts, while in other places there were giant-cells surrounded by mono- and polynuclear cells.

The culture on glycerin agar showed a brown centre which looked as if it were powdered over with dirty white dust. Inoculation of a rabbit from the culture gave a positive result as regards the production of a ringworm on the neck, but subcutaneous inoculation was negative. The treatment is far less easy than in the case of ordinary ringworm, and is to be aimed at increasing the general resisting power by tonics, etc., and by interstitial injections of antiseptics, such as iodine, all abscesses being, of course, opened and washed out with antiseptics.

A. W.

ON SKIN AFFECTIONS FOLLOWING THE USE OF AUREOL. Professor M. WOLTERS. (*Dermatologische Zeitschrift*, October, 1902, Heft 5, p. 603.)

THE author cites as his reason for this paper the statement of Richter that Aureol was an entirely harmless hair dye. He quotes three cases of his own—two males and a female—in whom applications of the dye caused a severe pustular dermatitis accompanied by œdema of the skin and sleeplessness. The symptoms set in from one to several hours after a single application, and in one case, in a male, after appearing to have greatly improved during four weeks' treatment, the original outbreak was succeeded by a severe eruption of urticaria which could be traced to nothing else, and therefore was put down as an after-effect of the dye. In another case severe sore throat and an erythematous eruption over the body caused the author to suspect simultaneous syphilis, though it afterwards appeared to be due to the Aureol only.

A. W.

A CASE OF ARSENICAL ERUPTION AND INTOXICATION. Dr. O. ROSENTHAL. (*Dermatologische Zeitschrift*, October, 1902, Heft 5, p. 609.)

THE patient was a doctor, aged 48, who, believing that he was suffering from mild lichen planus, first took Asiatic pills, then injected himself with diluted Fowler's solution, and then took enormous doses of Asiatic pills again. Early signs of arsenical intoxication seemed to have been regarded as further developments of lichen planus, hence the heavy doses. The total amount taken was about sixty grains of arsenious acid in three months. He had all the classical symptoms of severe arsenical poisoning, desquamating eruption, keratosis of the palms and soles, gingivitis, stomatitis, angina, loss of appetite, diarrhoea, jaundice and cardiac weakness with ataxy and other signs of multiple neuritis.

After rapid diminution, followed by complete cessation of the arsenic, he recovered sufficiently to leave the clinic in about a fortnight; he was, however, kept much longer under observation, and in about six months' time had entirely regained his health.

A. W.

ON A HITHERTO UNKNOWN APPENDAGE OF THE HAIR SYSTEM IN MAN: HAIR DISCS. Dr. FELIX PINCUS. (*Dermatologische Zeitschrift*, August, 1902, Heft 4, p. 465.)

"If one examine the flexor surface of his own forearm or upper arm by strong reflected light, he will see among the ridge and furrow network of the skin small roundish, glittering fields, $\frac{1}{4}$ to $\frac{1}{2}$ a millimetre across, most of them in definite relation to lanugo hairs." These small markings are called by the author "Hair Discs." They are found with greatest clearness in the adult male, and on the front and back of the lower part of the trunk, the belly and the shoulder blades. They are, however, found on anterior surfaces of the elbows, the flexor sides of the arms and the inner sides of the thighs. They do not correspond to the most hirsute parts nor to the most hairy individuals, being seen best at from 18 to 30 years of age. They are found to some extent in females, and also occasionally in children. The little bodies nearly always lie contiguous to a hair by one edge, and situated in such a manner that they lie in the acute angles that the hairs make with the skin. Occasionally one sees two such tiny nodules, one on each side of a hair, and very rarely several surrounding the hair. By examining with a strong glass (about 25 diameters stereoscopic), one sees a fine convex chagrin appearance like that of normal skin, but more regularly marked, often almost mulberry-like. Microscopically the nodule is seen to be a peculiar form of epidermis. Alcohol is useless as a fixing agent, but the structure is well seen in specimens fixed first in one in two thousand solution, and then saturated sublimate with hardening in alcohol. The upper surface of the body is slightly convex to almost plane, the under surface of the rete showing a smaller ridge-system than the surrounding skin. It is mostly composed of a tall palisade epithelium differing markedly from that elsewhere. The ridges are small and conical, and hardly longer than the cylinder cells themselves. (It is surely an error to describe the epithelial downgrowths as conical! Are they not sections of a ridge-system, though the author calls them "Zapfen" = pegs or taps?—A. W.) The physiological characteristics are a certain stiffness, so that tension of the skin which flattens out the network markings only causes these bodies to stand out more markedly, and a slighter degree of sensibility as estimated by the touch of a needle point. The structures are normal, as is seen by (1) their presence in all people, at least adults, and (2) their constant anatomical build. Similar structures have been described in relation to the larger spines of *Echidna hystrix* and possibly *Centetes*. Their time of appearance seems to rank them with the growth of the beard and other hair as part of the adolescent development.

A. W.

A CASE OF PRIMARY SARCOMA OF THE SKIN. GIOVANNI PINI. (*Archiv f. Dermat. u. Syph.*, July, 1902, p. 103. Five Plates.)

THE patient, a peasant woman, aged 25 years, presented on the trunk, about the lumbar, axillary, and scapular regions a number of tumours varying in size from an apple downwards. There were nine large tumours as well as several small ones. They were reddish-brown in colour or presented a violet tinge, and were dotted over with fine red puncta. Several of them were finely scaly on the surface, and one of them was ulcerated. The skin around the tumours was violet

and oedematous. The inguinal and axillary glands were enlarged. The first tumour had appeared more than a year before, and had been excised, but rapidly recurred. The patient died in hospital sixteen months after the tumours first appeared. At the post-mortem ascites, fatty degeneration of the liver, and sarcomatosis of the skin and lungs were demonstrated.

A histological examination of one of the tumours showed that it was a sarcoma of the spindle-celled type. It formed nodules chiefly in the hypoderm. These were, as a rule, encapsuled by septa of connective tissue. The cells varied considerably in size, but were all spindle-shaped or oval. Many of them presented mitotic figures.

J. M. H. M.

ON KERATOSIS UNIVERSALIS CONGENITA. NEUMANN. (*Archiv f. Dermat. u. Syph.*, August, 1902, p. 168. Two Plates.)

THE author describes a typical case of "Harlequin foetus" or "Hyperkeratosis universalis congenita." An 8 months male child was born dead, and presented a defective development of the face, absence of the upper lip, and deformity of the nose. Associated with this the skin was covered with horny plates like armour. These were yellowish-white in colour, and separated by red fissures of raw flesh. The fissure tended to have a horizontal direction, and to run circularly round the trunk and arms, while on the legs they had a more longitudinal direction. On the face they radiated irregularly from the mouth, breaking the skin up into variously shaped areas. On histological examination it was found that the most marked change had occurred in the stratum corneum, which was thickened to form masses like clavus. No nuclei were present in the horn-cells, which were perfectly cornified, so that it was an instance of a true hyperkeratosis. The stratum granulosum was absent, and no keratohyalin granules could be detected. The Malpighian layer was thinned and the papillary body flattened. The sebaceous glands, sweat-glands, and fibrous elements of the corium were unaffected. The writer concludes by referring to the fact that no more is known now with regard to the cause of this form of hyperkeratosis of the epidermis than was known to Lebert when he described it forty years ago.

J. M. H. M.

ON ACRODERMATITIS CHRONICA ATROPHICANS. (HERXHEIMER and HARTMANN. (*Archiv f. Dermat. u. Syph.*, July, 1902, p. 57, and August, 1902, p. 257.)

UNDER this heading the writers have contributed an elaborate paper based on a study of twelve cases of this peculiar atrophic condition of the skin. The cases which have resembled those which have been previously reported have generally been classed under the more indefinite title of idiopathic atrophy of the skin. In 1890 Hallopeau described a case to which he gave the name of Acrodermatite continuée, and the present title is an elaboration of this.

The histories of the twelve cases are reported, and a histological examination of three of them. Both clinically and histologically the disease presented a stage of inflammation and infiltration which was succeeded by one of atrophy. A few notes on the first case reported will serve to indicate the type of dermatosis. The

patient was a shoemaker, aged 41 years. The disease had begun seventeen years before he was seen by the writers, and at that time had appeared as small hard bluish-red nodules on the back of the right hand near the root of the fingers. A few years later the extensor aspect of the right elbow had become affected, then that of the left elbow and the back of the left hand. When first seen the patient presented lesions in all these situations, but associated with the deeply coloured infiltrated patches, there were also atrophic patches where no trace of infiltration could be detected, and in which the skin, though still bluish-red in tinge, was thin and resembled crushed cigarette paper. The patient was admitted into hospital, and during his stay there the root of the nose also became involved, and a reddish circular patch appeared.

The disease is characterised at first with inflammation and its accompaniments, but, as in Lupus erythematosus, the inflammatory disturbance is replaced by atrophy. It begins in the upper extremities and spreads centrally along the extensor aspects of the arms. In its whole course it is singularly chronic and resistant to treatment. Its etiology is uncertain, and neither age, sex, nor occupation seem to influence it in the slightest degree. The histological examination showed that in the early infiltrated stage there was an inflammatory process which was most marked in the pars reticularis of the corium. The blood-vessels in that situation were dilated, and there was an ordinary inflammatory infiltration of cells around them. The connective tissue-cells and fibres were here and there cedematous. The epidermis showed signs of hyperkeratosis and thickening of the prickle-cell layer. In the atrophic stage the cellular infiltration in the corium was more diffuse and was more granulomatous in character, plasma-cells and mast-cells being present in larger numbers than in the inflammatory stage; the thickening of the epidermis had disappeared in places, and the basal layer was pigmented.

The paper concludes with a tabulated list of their own twelve cases, showing the occupation, age, sex, time of onset, localization, etc., of the disease, and also of those which have been reported by Pellizari, Kaposi, Neumann, Pick, Jadassohn, and others, making in all twenty-seven cases.

J. M. H. M.

UNUSUAL TYPE AND LOCATION OF LUPUS ERYTHEMATOSUS.

MCMURRAY. (*The Australas. Med. Gaz.*, August, 1902, p. 412.)

In the case which is here briefly reported the unusual feature was the presence of the disease on the mucous membrane of the lips. Both lips were of a violet-red colour, swollen, and everted. The surface was not ulcerated, but was covered with thin scales. Here and there it was fissured and covered with crusts, which, when forcibly detached, left small bleeding points. At the junction of the skin and mucous membrane on the upper lip a fine line of scar tissue was present, and on everting both lips a highly vascular line marked the junction of the affected area with the normal mucosa. Patches of Lupus erythematosus of the seborrhoic type were present on the skin of the side of the nose and lobules of the ears.

Now that the attention of dermatologists is being drawn to the fact of the occurrence of this disease in the mucosa cases are more frequently reported, and it would seem that after all it is not so unusual a situation for the disease. The writer also refers to the fact that in New South Wales Lupus erythematosus

is much more common than *Lupus vulgaris*, and in 1,000 consecutive cases the proportion was thirteen to four.

J. M. H. M.

LINEAR SERPIGINOUS PYODERMATITIS. W. DUBREUILH. (*Ann. de Derm. et de Syph.*, August-September, 1902, p. 785.)

THE bacteriology of pus infections has been worked out in a good many clinical types, such as Impetigo of Tilbury Fox, Impetigo of Bockhart, Impetigo circinata, Pemphigus contagiosus tropicus of Manson, and others. But many clinical types still remain to be investigated, and Dubreuilh has had a series of cases which he considers himself justified in describing as a group, the chief characters of which are indicated in the above name. The two earliest cases were reported in 1899 from the author's clinique by Bernard; in the present paper four more are described. Of these six cases four were in men and two in women, and the age varied from 16 to 54. The occupations of these patients were various, and threw no light on the affection. The exposed and covered parts of the body suffered in equal degree. The general features of the disease are as follows: pustules develop along a line with many bends, giving the appearance of a gigantic burrow of scabies. But in the earliest lesions there is an initial serous inflammation before pustulation, and the suppuration is probably due to secondary infection. The breadth of the linear suppuration is from 1 to 7 millimetres, and the length from a few millimetres to 5 or 6 centimetres. The rate of progress is capricious; it may exceed a centimetre a day. The shapes assumed by the advancing line are very variable. The disease lasts two or three months, without much alteration of the general health; but itching and painful smarting are sometimes present. The microscopical examination of the pustular furrows has given inconstant results. In the earliest serous inflammation, great abundance of eosinophiles was noted, and no micro-organisms were found. In older lesions the eosinophiles were also numerous, but small cocci were found as well, which gave cultural characteristics of the yellow and white staphylococcus. These, however, are probably secondary, and the author thinks the primary infection may have been streptococcic, since this was demonstrated by Auché, in the earlier cases reported by Bernard. All kinds of antiseptic dressings proved efficacious in treatment, but the most successful application was a painting of the entire furrow with nitrate of silver (1 in 80). The main distinctions of this type from ordinary impetigo are the linear evolution of the pustules, and the greater degree of inflammation around the lesions. It bears a certain resemblance to the rare disease called "larva migrans," by Russian and German writers, the "creeping disease" of English authors. In this also the burrows of scabies are faithfully imitated. This fact suggested a parasitic origin, and this was demonstrated* in some of the Russian cases, in which a small worm was found which had penetrated the skin. But the furrows in these cases were only very rarely multiple; the linear progression was uncommon; and there was no suppuration.

The four new cases are described in detail.

E. GRAHAM LITTLE.

* Dubreuilh, *La Pratique Dermatologique*, Tome I., p. 863.

A CONTRIBUTION TO THE STUDY OF THE SUPERFICIAL DERMATOSSES DUE TO VERMIN. BALZER and SCHIMPF. (*Ann. de Derm. et de Syph.*, August-September, 1902, p. 792.)

A LABOURER, aged 68, had suffered for fifteen years from varicose ulcers of both legs. On the suggestion of a companion he kept the ulcers covered for some days with leaves of a plant common in the country side, *Tussilago farfara*; while wearing this dressing, he slept frequently in the open air during the heat of the day, at the side of a pond. Taking this primitive dressing off, after wearing it continuously for three to four days, he found the ulcers swarming with larvæ, which were identified as belonging to the species "*sarcophila magnifica*," by M. Mégnin. These larvæ are meat-eating and the ulcers had increased in depth and size as a result of their presence. It is probable that they had been deposited in the ulcers during his sleep near the pond, as above-mentioned. In the summer of the following year he was again seen at St. Louis, with a similar contamination of the wound. Treatment with carbolic acid lotions proved speedily effectual in destroying the larvæ on both occasions.

In the second case, a woman, aged 50, described as a dressmaker, but in the most abject poverty, was admitted into St. Louis with an extremely fetid exudation on the scalp, which was swarming with lice, and worms, the latter being from $1\frac{1}{2}$ to $\frac{1}{2}$ centimetre long. Compresses of petroleum were applied to the scalp, which was thoroughly disinfected. It was then found that there were no ulcers of the scalp as had been expected, the skin being intact. The fetid exudation had apparently been due to the secretions of the livestock living in the hair! The worms were examined by M. Gravier, and pronounced to be of the genus *Muscidia*, species *Lucilia*.

E. GRAHAM LITTLE.

ON MULTIPLE INITIAL GANGRENES OF THE SKIN. CARLE. (*Ann. de Derm. et de Syph.*, October, 1902, p. 865.)

THE patient whose case is described in this paper was a zinc-worker, aged 21. No facts relevant to the disease were elicited in his family or personal history. On his return from the usual annual period of twenty-eight days military service the patient noticed some swollen glands in the right axilla, which were painful. He had at the same time headache which was severe enough to compel him to rest, and a general feeling of fatigue. This condition of things lasted for five days and then disappeared. But about the same time he noticed on the skin of the upper lip on the left side between the ala nasi and the mucosa of the lip a small red papule, flat, indolent, not itchy, which he took no special note of. A second papule of the same kind appeared shortly after on the lower lip, and a third on the cheek near the right eye. These lesions gradually enlarged and became covered with yellow crusts. Fifteen days after he consulted a medical man who prescribed sublimate baths and iodides. The crusts fell, leaving suppurating ulcers, and at this stage he came under observation of the author, having been ill about a month.

The initial element in the eruption was always a small papule, of the size of a pin's head, occurring on any part of the skin. In four or five days this would enlarge, and the centre would become covered with a white scaly scab, with an

erythematous areola. From this condition development continued on three lines. Either (1) the scab increased in size to the dimensions of a franc, falling off in about fifteen days, and leaving a deep-red infiltrated sore which did not heal, or (2) the erythematous areola was more extended and deeply infiltrated, the scab more indolent, and finally after a month this would fall off, leaving an ulcerated surface which would heal after a few days, and a vividly-red scar remain, or (3) there would be a rapidly-necrotic process, and a definite line of demarcation would separate the central necrosed area from the peripheral erythematous portion: the ulceration would persist for six or eight weeks, and then when the slough was shed, rapid cicatrisation would take place, the scar being supple and not red.

The first attack of this nature occurred in January, 1901. The ulcerated surfaces were treated with the electro-cautery and with curetting and dressings of zinc chloride, and did well. The next attack was in February, when the eruption became generalised on the limbs. This was accompanied by deep ulceration of the tonsils, and swelling of the submaxillary glands. He remained in hospital for six weeks, and was treated with chloride-of-zinc dressings. He returned again in May, with lesions on the face and scalp. The ulcers in the latter position were especially intractable, and there was severe headache, which was best relieved by phenacetin. He was a patient on this occasion for two months. In August he was again seen and was in a deplorable condition with ulcers as big as a plate on the loins and buttocks. In November the left arm and the ear were the seat of profound ulceration, accompanied by pain and enlargement of glands. Again in January, 1902, there was a less severe eruption, affecting principally the scalp, the penis, and scrotum. From this time the disease became chronic, with occasional exacerbations. The body has, of course, become riddled with scars.

The most careful investigation of the patient's nervous system throughout this long observation revealed absolutely no defect. Sensation was normal, the corneal and tendinous reflexes were natural, the muscular reflexes were exaggerated. The urine was free from sugar and albumen. The secretions were examined microscopically, and no bacilli were found, such as have been described by Demme and Rotter in similar cases. Staphylococci were present in abundance.

Carle proposes a classification of cases of gangrene into primary and secondary, grouping in the first class those cases in which there is no constitutional disease, such as diabetes, to explain the attack, and in which the lesions are multiple and become spontaneously necrotic. In the second class he groups all those cases which are apparently due to general illnesses, including poor nutrition. Probably the cases are infective, but their bacteriology has not yet been satisfactorily worked out.

E. GRAHAM LITTLE.

THE BRITISH JOURNAL OF DERMATOLOGY.

MARCH, 1903.

“ERYTHEMA MULTIFORME AND LUPUS ERYTHE-
MATOSUS: THEIR RELATIONSHIP TO GENERAL
TOXÆMIA.”

BY JAMES GALLOWAY AND J. M. H. MACLEOD,

From the Dermatological Department, Charing Cross Hospital.

ALTHOUGH certain forms of toxæmia have been recognised for a long time as the most important factors in the etiology of Erythema multiforme, it is only comparatively recently that the attention of dermatologists has been called to the connection which also exists between the process of toxæmia and Lupus erythematosus, and to the close relationship of these two affections of the skin. The following cases of Erythema multiforme and acute Lupus erythematosus demonstrate so clearly this relationship that we have considered them worthy of being put on record.

CASE I.—*Erythema Multiforme, associated with Nephritis.*

Lilian H., a kitchen maid, aged 21 years, was admitted into Charing Cross Hospital on June 10th, 1902, with a temperature of 100·4° F., and suffering from a severe dermatitis affecting chiefly the hands, feet, and face.

Family History.—The mother and father, and three brothers and three sisters of the patient were alive and in good health, and there was no history of tuberculosis or rheumatism in the family.

Past Personal History.—Up to the present illness the patient had enjoyed excellent health. She had not had measles, nor scarlet fever, nor had ever suffered from rheumatism.

Present Illness.—The present illness had begun about six weeks before admission into Charing Cross Hospital, with swelling of the feet and legs which prevented her putting her boots on. This swelling gradually increased and became so severe that she was unable to walk, and obliged to leave her situation. She sought advice at Westminster Hospital, where she was admitted. At the time of admission she noticed that the skin of her face was flushed instead of being rather pale, as it usually was. According to her own statement, a week later the flushed areas of each cheek became tense and irritating, and became covered with scabs. These soon spread over the chin and the upper and lower lips. Red patches then appeared on the hands and feet, but these lesions were dry and had no crusts. On account of the skin-affection Dr. Colcott Fox was consulted about the case, and the appearance it presented at that time suggested to him that it was either a case of acute Lupus erythematosus, or of Erythema multiforme. Owing to the closing of Westminster Hospital for cleaning purposes the patient had to be discharged, and we are greatly indebted to Dr. Fox for having had her transferred to Charing Cross Hospital, where she first came under our observation on June 10th, 1902.

State on Admission to Charing Cross Hospital.—When she was admitted she was evidently seriously ill and very weak, and her skin was much involved. She was a fairly well-nourished girl of medium height. At the time of admission to hospital her temperature was 100·4° F., her respiration 48, and her pulse 130. An examination of her heart, lungs, and liver revealed no abnormal physical signs. The most noticeable feature of the case was the state of her skin.

Appearance and Distribution of the Eruption.—The skin of the face was flushed. There were symmetrical red patches on the cheeks which met across the nose, reached up as far as the eyebrows,

slightly involving the eyelids, and extended down to the chin. The edges of the red areas were irregular and slightly raised, owing to the presence of œdema which was most marked about the lower eyelids. Red patches were also present behind the ears. These red areas were here and there covered with purulent crusts, and there was a tendency to desquamation and to the formation of vesicles, several of which were hæmorrhagic. The crusts were most numerous about the ears, lips, sides of the nose, and the chin. The skin of the backs of the hands and dorsal aspects of the feet presented variously-sized erythematous blotches, several of which were slightly raised and discoid, and about the size of a sixpence. On the backs of the fingers there were several small bullæ, while in the centre of a number of the smaller lesions on the arms a vesicle had formed, or this had broken down with ulceration and sloughing. The tendency of the lesions to ulcerate was most marked around the nails of the fingers, which presented the appearance of a perionychia and involved the neighbouring skin. On the forearms there were numerous small erythematous lesions which had not gone on to vesiculation and ulceration. The type of lesion which occurred on the feet and ankles, and to a less extent on the legs, was similar in every respect to that on the hands and forearms. It was a multi-form eruption which began with erythematous macules and blotches; these tended to form vesicles or bullæ, and finally to become covered with scabs or to ulcerate and slough. All stages in this process of evolution could be detected. The mucous membrane of the mouth was also involved. The tongue was swollen and fissured, and tended to bleed. The gums were also swollen, and blood oozed out from the sockets of the teeth. So severe was the affection of the mouth that the swallowing of even cold liquids was attended with much pain and discomfort.

An examination of the *urine* revealed certain abnormal conditions which had an important bearing on the case. When first examined after admission the urine had the following characters:—

Quantity, about 8 ozs. (The quantity of the urine was difficult to ascertain owing to the condition of the patient. It was small in amount, but the quantities noted are no doubt less than the actual amount passed.) Specific gravity, 1·021; reaction, faintly alkaline;

urea, 3 per cent.; albumen, .8 per cent.; deposit of urates, and epithelial, hyaline, and finely-granular casts, and leucocytes.

The *treatment* adopted was on purely general principles. Weak antiseptic lotions were kept constantly applied to the affected skin, and mouth washes of various descriptions were ordered. Salicine and quinine were prescribed internally, and liquid food was rendered necessary owing to the state of the mouth. In spite of treatment the patient gradually lost ground.

The following additional notes are taken from the hospital case sheets :—

June 21st.—The skin of the face is slightly less flushed and the crusts have been cleared off. During the last few days the temperature has ranged between 100° F. and 103° F., the pulse has averaged 125, and the respirations 34.

The urine is turbid; quantity about 8 ozs.; acid in reaction; specific gravity, 1·020; gives a cloud of albumen; urea, 2·4 per cent.; shows epithelial casts.

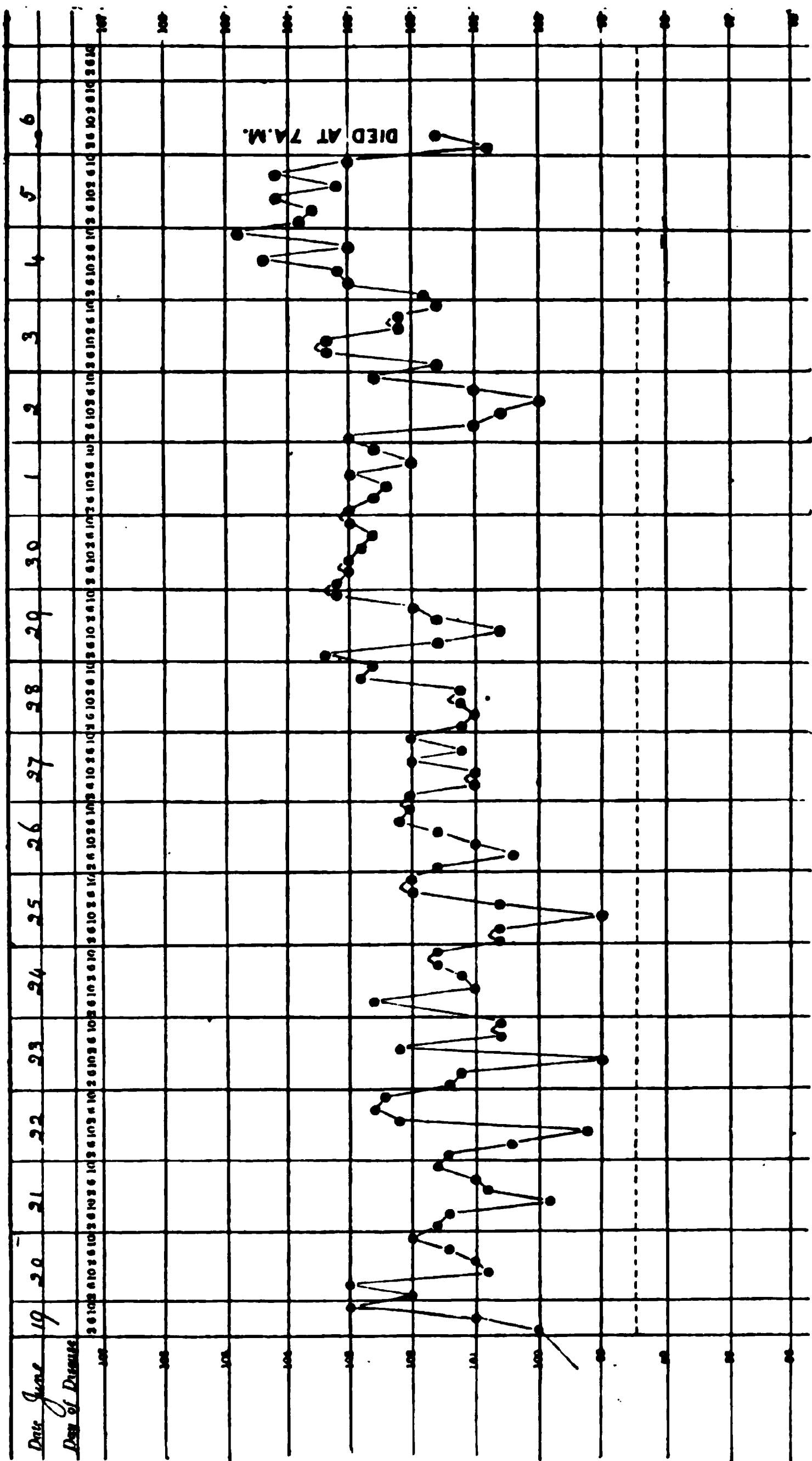
On June 30th.—The temperature has been very remittent, rising to about 103·2° F. The patient complains of a difficulty in breathing, and there is a hard cough, which troubles her all day and all night. The crusts have been cleared off the face, except on the lips, where there is some bleeding. There is very little improvement in the hands and feet, and fresh lesions keep coming out. Several new lesions have appeared on the forehead at the roots of the hair.

On July 3rd the patient's temperature was 103·4° F., and the respirations 52. The patient had a very bad night, having had a fit which lasted about three minutes, the face was convulsed, and there were twitching movements of the arms. There is no improvement in the eruption on the face, hands, and arms. There is slightly more bleeding than usual from the lips.

Urine. — Quantity, about 16 ozs.; dark in colour; acid in reaction; specific gravity, 1·017; urea 2·5 per cent.; a cloud of albumen; no casts or red blood corpuscles.

The blood was several times examined both for micro-organisms and for pathological changes, but with negative results.

The patient's condition now became rapidly worse. She had several more convulsions, and died on the 6th of July.



TEMPERATURE CHART OF LILLIAN H.

POST-MORTEM EXAMINATION.

The post-mortem was done by Dr. Cecil Bosanquet on the 7th July, in the presence of one of us, and the following is abstracted from his report :—

Morbid Appearances.—Body rather thin. Rigor mortis strong.

On the face, hands, forearm and feet there was an erythemato-vesicular eruption. On the face there were large blotches occupying the cheeks and nose, and extending back to the ears and down to the neck. On these patches there were several raised flat plaques, and a slight tendency to vesiculation and desquamation in flakes. Associated with the eruption on the face there was œdema, which was most marked about the eyelids. On the hands the eruption consisted of blotches, raised red papules and plaques. On the fingers these tended to become vesicular, and about the roots of the nails the skin had desquamated and there was some necrosis. The eruption was chiefly confined to the backs of the hands, the palms being only very slightly affected. On the feet there was a number of red plaques, similar to those on the hands; these were located chiefly about the toes and soles. Around the toe-nails the skin had necrosed and there was a tendency to suppuration.

A small piece of skin was removed from the outside of the right little finger for microscopical examination. It included several small flat papules about the size of split-peas.

THORAX.—*Pericardium* contained about 4 ozs. of serous fluid with flakes of lymph, and there was a recent pleurisy over the surface of both lungs.

Right Lung.—The apex of the upper lobe is dark red in tint, consolidated and airless. The rest of the lung substance is œdematous, and the bronchial tubes have much muco-pus.

Left Lung.—Normal.

Heart.—Weight, $13\frac{1}{2}$ ozs. ; normal.

Larynx and Trachea.—Tonsils red and ulcerated. On the dorsal aspect of the tongue there is a sharply margined triradiate ulcer.

This ulcer was also excised for histological examination.

ABDOMEN.—*Peritoneal Cavity* contains $1\frac{1}{2}$ parts of turbid serous fluid with flakes of lymph.

Liver.—Weight, 3 lbs. 6 ozs. Pale and fatty.

Kidneys.—Weight, 5½ ozs. each. Rather pale in colour. Capsule strips readily. SIGNS OF TUBULAR NEPHRITIS.

Intestines.—Catarrhal throughout. No ulceration or enlargement of the follicles.

Spleen.—Weight, 9 ozs. Preserved for bacteriological examination.

Stomach.—Normal.

Uterus and Appendages.—Normal.

Retro-peritoneal Glands.—Somewhat enlarged.

REPORT OF THE HISTOLOGICAL EXAMINATION.

(1) The piece of skin excised from the little finger of the right hand was about three-quarters of an inch long. On microscopical examination it presented the following peculiarities:—

The most noticeable changes were those in the epidermis; for in the corium there was only a simple inflammatory disturbance made evident by a dilatation of the papillary and sub-papillary blood-vessels, an inflammatory infiltration of small connective-tissue cells and leucocytes around the dilated vessels, sweat-coils and ducts, and a widening of the tissue-spaces between the white fibrous bundles, which was most marked near the epidermis, where there was actual œdema of the collagen.

All these signs in the corium were simply the usual evidences of an acute inflammation of the skin, and were more suggestive of the Erythema multiforme than of Lupus erythematosus. The epidermis showed definite changes. The basal layer was more or less blurred, and this was especially the case where the œdema of the underlying corium was most intense, and the inflammatory infiltration had approached the surface.

The Malpighian layer was œdematous throughout, the œdema occurring not only in the inter-epithelial lymphatic spaces, but in the prickle-cells. In one or two places there was vesicular formation. Two of these early vesicles were situated immediately below or occupying the position of the granular layer, another was deeper down, near the basal layer. The vesicles were evidently due to a rapid distension of the lymph-spaces with fluid causing stretching and breaking of the inter-epithelial fibres, and the formation of a

unilocular vesicle. The prickle-cells in the neighbourhood of the vesicle were swollen, their nuclear spaces distended with fluid, and their nuclei were œdematous and stained faintly. Fluid collected also in the meshes of the intra-cellular spongioplasm forming a "reticulation" in Unna's sense of the term. Other degenerate prickle-cells were also detected in which the spongioplastic network was not visible, and which had lost their prickles and become changed into roundish homogeneous masses corresponding to the "balloon-cells" of the same observer. In these masses nuclei were present, in several instances being pushed to one side, and occasionally the nuclei could be detected showing that in spite of the degenerative process in the protoplasm of the cell the nuclei still retained their vitality.

Where the œdema was excessive the transitional layers were absent, no keratohyalin granules could be found in the cells, and the overlying stratum corneum was imperfectly cornified, its individual cells were swollen, their nuclei persisted, though they were somewhat shrunken, and the cells tended to adhere in flakes or scales. In other words, the condition known as "parakeratosis" was present. In some places where the œdema was less marked the transitional layers had not disappeared and the stratum corneum was healthy. In one situation a superficial vesicle had become purulent, and was packed with pus-cells and leucocytic debris.

These histological appearances gave evidence of an acute inflammatory disturbance with a marked tendency to vesiculation of the epidermis; but there was nothing absolutely conclusive of the diagnosis in the type of vesicles, since ballooning, reticulation and the other changes in the cells occur also in Herpes zoster, occasionally, though rarely, in Eczema, and in Variola.

The appearance of the epidermis was not that of eczema, there was not the general profound œdema, nor was the interference with the process of cornification so marked. Nor did it correspond with Lupus erythematosus, for there was no thickening of the horny layer nor plugging of the follicles, such as occurs in that disease. It suggested far more closely Erythema multiforme or Herpes zoster.

The ulcer excised from the tongue had the following peculiarities :—

At the edges of the ulcer the epithelium was markedly œdematous

and in one of the down-growing processes a vesicle had begun to form. Near the ulcer it had become attenuated and macerated. The floor of the ulcer was formed by the corium. Superficial inflammatory changes were present in the sub-epithelial layer consisting of dilatation of the vessels and œdema, but the underlying muscular layer seemed healthy.

The picture presented by the epithelium of the tongue was closely similar to that of the epidermis, and showed precisely the same type of change modified by the different character of the epithelium.

We take the opportunity of recording this case at some length as it is a good example of a class of disease which is under critical discussion. The young woman who suffered from this eruption died from nephritis. The violent dermatitis which so severely complicated the malady can hardly be doubted to have been the result of toxæmia produced by the disease, but it is only by the association of the two conditions that we are able to infer their causal relationship. When Dr. Colcott Fox asked us to take charge of the case the opinion in his mind had not yet been formed as to the exact category of skin-lesion this eruption should occupy, although the possibilities of Erythema multiforme, acute Lupus erythematosus, or some unusual exfoliating Dermatitis had all been considered by him ; and although the patient remained under our care for over a month till her death, and although she was seen by others in consultation with us, we had some difficulty in determining whether the skin condition should be considered as exceptionally severe Erythema multiforme, or as acute generalised Lupus erythematosus.

With this difficulty in mind, it may be instructive to draw attention, and record the further history of a case also recently under care at Charing Cross Hospital, in which the same difficulty was presented, but from the converse aspect.

CASE II.—*Lupus Erythematosus Associated with Cirrhosis of the Liver and Alcoholism.*

The patient was shown to the Dermatological Society of London and notes of her case appear in the *Brit. Journ. of Dermat.*, Vol. X., 1898, pp. 49 and 194 ; Vol. XI., 1899, p. 288. In this case it was admitted by all that the disease was the generalised form of Lupus

erythematosus, yet its close resemblance to severe Erythema multiforme was frequently noted.

The patient, also a woman, aged about 36 years, first came under observation in October, 1897, suffering from an intense erythema, with some œdema, distributed symmetrically and occupying the greater part of the skin of her face. Small patches of the same character were seen on both upper extremities. Although evidently seriously ill, she declined admission to hospital in the first instance, and attended as an out-patient.

After a period of about six weeks, as she became much worse in health, she at length consented to come under care as an in-patient. It was now (12th January, 1899) that she was presented to the Dermatological Society for the first time, when the opinions of Dr. Crocker, Dr. Fox, Dr. Pringle, Dr. Perry, Mr. Morris, and others were obtained, agreeing with that expressed above. The following was the condition at the time :—

“ The eruption on the face was not quite so acute as on the first consultation, although it was still very prominent ; but, in addition, patches of erythema with exfoliation of the epidermis were observed on the arms and hands. These patches were most numerous on the extensor surfaces. A few small ones were seen on the elbows, the backs of the forearms, and many were seen on the backs of the hands. Most of the proximal phalanges were occupied by patches of erythematous and slightly infiltrated skin, resembling in distribution the lesions in some cases of Erythema multiforme. Numerous erythematous and infiltrated patches were also seen on both palms. In addition to these situations typical patches of disease occupied the vertex, and were also to be seen on the back, and to a smaller extent on the lower extremities. Slight superficial atrophy of the skin could be observed in areas previously occupied by much more extensive patches of erythema.”

Note has already been made of the gravity of the patient's illness. She had almost continuous pyrexia, the temperature ranging up to 102° F. and suffered to a considerable extent from dyspnoea due to bronchial catarrh. Repeated examinations were made to discover whether pulmonary tuberculosis was present, always with a negative result. She had little appetite for food, lost flesh, and became so debilitated that grave fear was entertained that her illness might end

fatally at this time. No other form of disease was suspected, though doubtless the condition of her liver and other degenerative changes due to alcoholism, which eventually proved fatal, were present even at this stage of the malady.

Gradually the severity of the disease diminished ; she commenced to take food, to increase in weight, and the bronchial catarrh practically disappeared. The skin-lesions improved *pari passu*, till at length large areas of erythema on the face, arms, and hands had gone, leaving much smaller areas on the most characteristic situations, *e.g.*, cheeks, ears, extensor aspects of forearms and phalanges, tips of fingers, the seat of resistant lesions of the ordinary Lupus erythematosus type. Some of these also disappeared, and in their place rounded or oval patches of distinctly atrophied skin remained. (Portraits of the patient were exhibited to the Society at the meeting on the 11th May, 1898.)

The patient went home, attended the out-patient department regularly, and for some months remained in a fairly good condition of health, being troubled mainly by the patches of eruption, for which palliative remedies were employed. Her health beginning again to give way, and the eruption giving distinct evidence of increase, she was admitted to the Great Northern Hospital under our care, in a condition similar to that noted previously, though not so severe. It was at this time (July, 1898) that suspicions were entertained as to her habits, which were subsequently verified. She was again discharged from hospital much relieved, but returned for treatment to Charing Cross Hospital. For several months she continued under treatment, gradually becoming worse both in her general health from the condition of her liver, which was now evident, and so far as the skin manifestation was concerned.

She was again admitted as an in-patient to Charing Cross Hospital, and was brought before the Dermatological Society the second time (14th June, 1899). The following account was published :—

“ This patient has been under continuous observation since that date (12th January, 1898), and has suffered from a relapsing scar-leaving erythema, which still persists. At present the areas previously covered by the eruption show well-marked, fine, superficial atrophy of the skin, with destruction of pigment. The erythematous lesions are now present on the fingers, slightly at the borders of the

nails, on the elbows and one or two other situations. The eruption throughout the whole body has been remarkable on account of the very close simulation of the severer form of Erythema multiforme. When she came under observation in the first instance the severity of her illness could not be accounted for by the morbid conditions ascertained. She suffered from attacks of bronchitis, but no sign of tuberculosis was discovered. Within the last twelve months, however, she has developed characteristic *cirrhosis of the liver*, with enlargement of that organ. At one time the lower margin extended half-way between the costal margin and the umbilicus. The reason for this could not be determined, as the position and character of the patient gave no ground for suspicion of alcoholism. It has been ascertained, however, that the patient has for long been indulging excessively in the consumption of alcohol, and chronic alcoholic poisoning is no doubt the cause of the hepatic condition. In view of the recent theories as to the causation of Lupus erythematosus, it is noteworthy that in this severe attack of the disease, in which the type of Erythema [multiforme was closely approached, the only cause capable of producing a toxæmia of marked degree was chronic alcoholism with cirrhosis of the liver.”

We may be, perhaps, pardoned for not discussing earlier the alcoholic habits of this patient, when we report that she was a remarkably intelligent woman, apparently happily married, and had several children, who appeared well cared for. We should have had greater difficulty in discovering the alcoholic habit had it not been for information derived from a relative, who informed us that our patient had frequent fits of uncontrollable alcoholism, and that another sister, recently dead, had been a confirmed alcoholic.

The patient, shortly after the last date, went home slightly improved in health, but in the course of a few weeks we had the news that she was dead, having suffered greatly from the consequences of the hepatic disease, and from the intense discomfort and irritation arising from the skin.

It is a matter for regret that an examination *post-mortem* was not obtained in this case.

Putting aside the vexed question of the relationship between alcoholism and cirrhosis of the liver, the thought that rises in our minds on consideration of this case is, that in the presence of two

agents so powerful in producing toxic effects as alcohol and hepatic cirrhosis it is foolish to seek for another powerful factor, especially one so obscure and uncertain in its effects as some remotely acting consequence of tuberculosis, as has been suggested by some observers.

REMARKS ON THE TWO CASES.

In comparing our two cases, one of the most noteworthy features presented by them was their striking clinical resemblance both with regard to the distribution of the eruption and the character and course of many of the individual lesions. So great was this resemblance that there was considerable difficulty presented in the diagnosis of the two affections. Vesiculation and bullous formation, it is true, was present in the former case and absent in the latter, but this objective sign has been noted in association with Lupus erythematosus sufficiently frequently to render it of comparatively little value as an important distinguishing symptom. Atrophy and scarring was absent in the case of Erythema multiforme, but had the patient lived longer and the ulceration healed a scarring would doubtless have been produced, which, though different in type from that of chronic Lupus erythematosus, might still have occasioned difficulty in the diagnosis.

We were also greatly struck by the close similarity which existed between the case of Erythema multiforme and that presented by the fatal case of Lupus erythematosus of the disseminated type described by Sequeira and Baelean, and depicted in this Journal in October, 1902. Indeed, their illustration may almost be taken to represent the present case of Erythema multiforme.

On account of the close clinical resemblance of the two cases we were thrown back on the histological appearances to aid us in making a firm diagnosis, and even they were not so conclusive as might reasonably have been expected. In the case of Erythema multiforme we found that the cellular infiltration in the corium, though having much the same distribution as is usual in Lupus erythematosus, differed from that of the latter disease in character in being a simple inflammatory infiltration instead of a more chronic infiltration in which plasma-cells are generally present, and the

tissue spaces, though dilated, were not so markedly so as they generally are in Lupus erythematosus, where a condition is produced which has been graphically described as "canalisation." Nor did the state of the epidermis give us much assistance, as although in the chronic type of Lupus erythematosus there is hyperkeratosis and plugging of the mouths of the follicles, in acute cases this is replaced by œdema and parakeratosis.

From these facts we were compelled to conclude that in cases such as we have described the clinical and histological differences are, perhaps, more those of degree in a common process than of a totally different type. In ordinary chronic Lupus erythematosus the process of repair, which is part of the phenomenon of inflammation, is retarded by the transformation of the cellular exudate into fibrous tissue, while, as a rule, in Erythema multiforme the repair is complete, unless in exceptional circumstances where through the secondary inoculation of pus-organisms ulceration and scarring are accidentally added.

In both the cases described general toxæmia of severe degree existed. The effects produced corresponded in the one case to the rapid action of a virulent toxin circulating in the blood and causing an acute inflammatory disturbance in the skin leading to a fatal termination in a few months, and in the other to the action of a much less virulent toxin, prolonged for years, and setting up a more chronic type of dermatitis.

The observations recently published by Dr. Wilfrid Warde are noteworthy, as they seem to indicate that absorption of pyogenetic toxins may result in one of the forms of toxæmia concerned in the production of Lupus erythematosus.

It seems to us that the comparison of such cases, both clinically and pathologically, will do more towards the recognition of the true nature of Lupus erythematosus and the relegation of it to its proper position in the classification of skin-diseases, than the ill-rewarded search for tubercular manifestations or antecedents, or evidence sought from injections of tuberculin.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of the above Society was held on Wednesday, February 11th, 1903, Mr. Malcolm Morris in the chair.

The following cases and specimens were demonstrated :—

Dr. GRAHAM LITTLE showed : (1) A case of *Tuberculides* in a female infant, aged 2 years. There are very numerous papules with a necrotic centre distributed thickly over the legs, less thickly on the thighs, and again numerous on the arms. There are several on the face. The papules are in ill-defined groups on the legs, and most of them are of a deep purplish-blue colour ; some of them have a pitted centre, apparently where the necrosed matter has shelled out. The eruption commenced just after Christmas, and has continued to invade the extremities ever since. The child had a severe attack of measles eleven months ago, from which time she has been in poor health. She has a severe chronic nasal and ocular catarrh with much discharge. This has been examined by the pathologist to the Children's Hospital, who reports the finding of a diphtheroid bacillus in the discharge from both the nose and throat. The only tubercular history that could be made out in the case was that the father's grandfather and several of the father's cousins had died of phthisis. There was no history of tuberculosis on the mother's side.

(2) A case of a peculiarly-grouped eruption of pale flat papules in a female child, aged 2½ years. The papules are indistinguishable from those of *Lichen planus*, and the case was shown as an example of this disease. The distribution is as follows :—A patch of papules covering an area the size of a five-shilling piece, on the inner side of the right knee ; this was the earliest in appearance and has persisted for six months ; the papules cover the circular area closely, but are discrete. There is another similar but smaller patch on the right calf, and on the left calf and upper part of the left leg. A few discrete papules are present on the right, and one or two on the left labium majus. In the right groin, just above the line of Poupart's

ligament and parallel with this, there is an arrangement of the same type of papules forming an elliptical figure, the boundary being made up of discrete papules, and some similar papules being contained within the ellipse, which is $1\frac{1}{2}$ by 2 inches, the long axis being in the line of the groin. There are two exactly similar patches of much the same size on the other side, one in the line of the groin but a little higher in position than is the case on the right side, and one, with the same oblique direction, halfway between the navel and the groin. All of these patches have persisted for some months, and are itchy; they have remained papular throughout. There are no lesions on the mucous surfaces. The rest of the body is perfectly clear.

Dr. CROCKER thought the case was rather of the nature of Vidal's *Lichen simplex chronicus*. Dr. Pringle and Dr. MacLeod agreed with the exhibitor that it was *Lichen planus*. Dr. Whitfield and Dr. Colcott Fox suggested that it was a *seborrhoide*.

(3) A case of a severely pruritic very extensive eruption in a woman, aged 31, who stated that the eruption had lasted since the first year of infancy, being ascribed to the primary vaccination. The case was shown as "*Prurigo of Hebra*." She is a Yorkshire woman with no Jewish inheritance. The eruption consists for the most part of firm small papules much scratched, and the skin between is harsh and dry and thickened. On the arms there is definite lichenification in front of the elbows, and for a hand's breadth above and below this. There is much irregular pigmentation, especially on the abdomen and chest. The papules are thickly aggregated on the front of the chest, on the neck, on the backs of the arms and the fronts of the thighs, on the buttocks (especially closely there), and on the face; they are present, but less numerous, on the legs. There are only a few on the abdomen and back of the trunk. The glands in the groin, axilla, and neck are all enlarged. She has never been free from the eruption, but it is worse in the spring and autumn.

Some difference of opinion was expressed as to the nature of this case.

Mr. MORRIS and Dr. CROCKER maintained the diagnosis of *Prurigo of Hebra*; another opinion was that it was a chronic eczema.

(4) A case of *Rodent ulcer* of the left lower eyelid in a woman, aged 50. The disease had commenced nine years previously. The diagnosis had been uncertain up to a year ago. It was then thought to be probably rodent ulcer by Mr. Morris, and treated with X-rays.

She had had altogether four courses of X-ray treatment in the last twelve months, each of about eight exposures. She had appeared to benefit for the time, and the ulcer had become shallower after each treatment, but she had been unable to attend for longer periods.

(5) A case of *Canities* in a boy, aged 9 years, with leucodermia and melanodermia of the body. The condition had commenced eight months previously. It had not been preceded by Alopecia. The hair of the head was now mostly white, with two or three tufts of dark brown hair irregularly placed in the scalp; the mother states that the skin of the head is white where the white hair is, and dark where the dark tufts are seen. The child has at the present time some tinea of the scalp, and the hair has been shaved previously for this condition. There is some history of occipital headache, but this was noticed before the disorder of pigmentation. There was no history of any other members of the family having suffered from premature whitening of the hair.

Dr. J. J. PRINGLE demonstrated (1) a case of *framboesiod Syphilis* in a man, aged 38 years, an employé on board an ocean steamer. The patient stated that his last connection with a woman took place ten weeks before exhibition, his previous coitus having been thirteen weeks before that date. Three days after the last coitus he noticed several lesions on the penis and soon afterwards the lesions still present on the right leg. The face and gluteal fold became affected about a fortnight previous to exhibition, while the forehead and lips had been involved for ten and five days respectively. All the manifestations of syphilis presented by the patient were of uniform type, and that type was tertiary rather than secondary in character. The lesions consisted of groups of raised, firm, fungating nodules with surrounding purplish discolouration and distinctly framboesiod in character, situated in the right popliteal space, the supraciliary regions, the right lower lip and the intergluteal fold. Their distribution was markedly asymmetrical. When the surface lesion was removed mechanically circular punched-out ulcerations were exposed, and a foetid discharge covered the base of the ulcers. There was also a deep punched-out ulcer of the left tonsil which gave rise to no subjective symptoms. The patient's general health was good. There were no glandular enlargements. The woman with whom the

suspect coitus had taken place was stated to be a prostitute in Cape Town of pure French origin. The points at issue in the case were whether it was an example of malignant syphilis of tropical type or a late tertiary syphilis originating from a source anterior to that referred to, in which the secondary symptoms had passed unobserved. The exhibitor also indicated specially the superficial resemblance of the lesions to those of true frambœsia and expressed his opinion that the erroneous view entertained in some quarters as to the identity of syphilis and frambœsia was based upon such cases.

(2) A case of *Lupus erythematosus nodularis* in a woman, aged 28. The main patch of disease was in the frontal region of the scalp and was the size of half-a-crown. Its surface was unusually lumpy; its duration twelve months. Behind the left ear was a typical patch of atrophic Lupus erythematosus of four months' standing. On the left cheek, immediately in front of the angle of the jaw, was an aggregation of firm nodules more easily felt than seen, stated to have been present for two months. It covered an area the size of a florin. Its surface was erythematous, but not ulcerated or even scaly, and the erythema was not clearly margined. There was a very strong family history of tuberculosis, three of the patient's sisters having died of pulmonary tuberculosis at the ages of 19, 20 and 21 respectively. The patient herself was, however, in robust general health.

Dr. RADCLIFFE-CROCKER exhibited a case of what in Germany is called *pseudoleukæmic Prurigo*.

The patient was a piano finisher, aged 41. He stated that in February, 1902, he scratched his finger, and it healed rapidly, but a week later a lump formed in his right axilla; it became smaller after being painted with iodine, but subsequently enlarged again, and in May of that year there were several lumps as big as a bantam's egg with processes from them extending downwards. For these he went to University College Hospital, and on May 20th they were removed by Mr. Bilton Pollard. Soon afterwards the glands in the left axilla enlarged and he again went to the hospital in the middle of December, 1902. He began to feel itching at the end of July and this has continued ever since, but was at its worst at the end of December, but is not so bad now, the relief being due he thinks to borax lotion. The glands, when he came under the exhibitor's care on

February 10th, 1903, were much enlarged in the left axilla and to a less extent in the inguinal and post-sterno-mastoid regions. The spleen was not enlarged. There had not been time to examine the blood.

The skin-lesions were chiefly on the buttocks and upper half of the thighs. Some of them were felt as superficial nodules of the size of a hemp-seed and nearly all were slightly scabbed from scratching. There were also numerous superficial scabs without underlying papules and in addition there were marks of old lesions in the form of superficial scars from a millet-seed to a hemp-seed in size. On the lower half of the thighs the lesions were much less abundant, but again increased in number on the lower half of the leg, where there were numerous purplish and scabbed lesions from one-eighth to one-third of an inch in size. In front there is scarcely anything in the upper half of the thighs and in the groins, but they were fairly numerous on the lower third and on the front of the leg. They were sparse on the front of the trunk and there were only about half a dozen on the arms; above the sacrum they were not numerous, but they were more abundant on the shoulders. The face and neck were clear.

There was a general concurrence in the diagnosis, and the exhibitor mentioned another case in which in a young man severe itching had developed without any other symptoms except moderate enlargement of the post-sterno-mastoid glands, which, as there was a strong family history of consumption, were regarded as tubercular. He also complained of pain over the right kidney and down in the course of the ureter. There was nothing in the urine to explain this. Subsequently other glands enlarged and the diagnosis of Hodgkin's disease was made. The pruritus continued unabated and even aggravated until the death of the patient about two years from the onset, but the narrator had not seen the patient after the early stage so could not state whether there were special skin-lesions. He remarked that the presence of severe pruritus with enlargement of even a few glands should suggest a pseudo-leukæmic rather than a tubercular origin.

2. *A Case for Diagnosis.* A girl of 22 with some deep ulcers, seven or eight in all, on the lower half of the right leg; she said they were very painful, but were beginning to heal. She had also numerous pigmented scars on both legs; some of these were oblong in shape, the long diameter being perpendicular; others were elongated ovals with the lower end of larger diameter than the upper. Much discus-

sion arose as to the pathology of the ulcers, Mr. Malcolm Morris and other members suggesting the possibility of their being artificial. The exhibitor then said that that was the conclusion he had come to chiefly from the shape and otherwise unaccountable character of the lesions.

Dr. SEQUEIRA showed a man, aged 44 years, with an infiltrated patch of skin on the left side of the nose. The question raised was whether the disease was Lupus or *Syphilis*. The affected area was oval in shape, reaching from half an inch below the lower lid to the naso-labial junction. The centre was of a red-brown colour, while the margin, which was elevated, presented the peculiar jelly-like appearance characteristic of Lupus vulgaris. The central part was slightly depressed, and showed slight superficial desquamation. There was no breach of surface and no evidence of past ulceration. The appearance of the lesion certainly justified the diagnosis of Lupus vulgaris which was made by some of the members. The history, on the other hand, was strongly against this. The disease began seven months ago, the patient at that time having a severe nasal catarrh. He stated that as the catarrh subsided, he noticed a small discolouration on the left side of the nose. He attributed it to the constant use of his handkerchief. The spot gradually increased in size, but there was no pain. About a month ago he was able to feel a raised edge, and since then the increase in size had been very rapid. An examination of the interior of the nose showed nothing abnormal. The disease was limited to the skin, being freely movable over the cartilage. The patient denied having had syphilis, and there were no signs of that disease present. He was the father of three healthy children, and his wife had had no miscarriages. Iodides were said to have been tried, but Dr. Sequeira was unable to say for how long or in what doses, the case having only come to his notice a few days before the meeting.

Mr. ARTHUR SHILLTOE showed a case of *erythematous Syphilide*. The patient, a clerk, aged 34, had intercourse in October. Three weeks later he developed a sore at the frenum, which his doctor thought was not syphilitic; it healed entirely in a week under black wash.

On January 26th he attended the Lock Hospital. There was then no adenitis, very slight thickening at the frenum ; no sore throat, but a general erythematous eruption. He could not say what medicine he was taking, as, thinking the eruption might be due to some drug or some gastro-intestinal irritation, he was given a purgative and told to return for further observation. Perhaps against this theory were the facts : (1) that it had persisted since Christmas, and (2) that there was little or no irritation.

On Monday, February 9th, he was seen again, and before undressing was asked how the eruption was. He said on that morning it was much better, and had practically disappeared ; but on stripping him it was as evident as it had ever been. Further examination showed increased thickening of the frenal scar, general adenitis, affecting chiefly the axillary, mastoid, sub-occipital cervical, and two glands over the back of the trapezii muscles, in a rather unusual situation, and some ulceration about the right tonsil.

Dr. WHITFIELD brought forward a woman, aged 43 years, suffering from a peculiar symmetrical eruption over the hypogastric and sacral regions and the upper parts of the thighs. The duration of the eruption was said to be since Christmas, 1902, and the lower part of the abdomen was the first to be affected.

When viewed by daylight it was seen that the whole of the above-mentioned sites were occupied by a sheet of yellowish-red eruption, with an almost if not absolutely smooth surface, and a somewhat well-defined serpiginous border. On closer examination it was found that the eruption was made up of dilated capillaries and venules, which could be emptied on pressure, and contributed the red portion of the colouring, and of a diffuse yellowish pigmentation, not fading on pressure, and giving the fawn-colour which was so noticeable. The surface was not scaly, but was perhaps slightly harsh, the impression given being that this was secondary to the deep disturbance rather than the essential lesion. There was no infiltration present, and the disease had not altered since first seen, a few days before. There was a noticeable congestion round a few of the outlying follicles beyond the main sheet, but no turgescence or erection of these was to be made out. The eruption was extremely irritable, and up to the date of exhibition treatment had been directed against this symptom

only. Dr. Whitfield said he had not yet examined the urine, as he had been unable to obtain any on the patient's first visit, but a pretty thorough examination in other respects had elicited nothing of interest. A careful inquiry as to the possible ingestion of drugs had also been answered in the negative.

As regards the diagnosis, Dr. Whitfield said that a casual glance would suggest the inclusion of the eruption in the large and ill-defined class of seborrhoic eruptions. A more careful examination had, however, convinced him that the surface disturbance, which was infinitesimal, was secondary to the continued congestion of the superficial part of the true skin. He was therefore unable to offer any diagnosis whatever, and it was especially with the intention of raising discussion and criticism that he exhibited the case. He thought that all the members would be familiar with somewhat similar types of eruption, and he had found them usually very rebellious to treatment.

Dr. RADCLIFFE-CROCKER said he should include the case under the seborrhoic heading, as he thought the pityriasis of the skin was primary.

Dr. J. J. PRINGLE said he thought the case was not primarily a surface catarrh, but was more nearly allied to an angiomatous condition; he reminded the members of the case published by Schamberg in the *Brit. Journ. of Dermat.*, Vol. XIII., 1901.

Dr. COLCOTT FOX expressed great interest in the case, and said that he did not often see cases quite similar to it. He believed with the exhibitor, that the harshness of the surface was secondary, and that it was not of the same type as the seborrhoïdes.

Dr. WHITFIELD promised to report on the case later.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, January 28th, Dr. STOWERS in the chair.

Dr. EDDOWES showed (1) a young woman with *Lichen planus* of four months' duration, scattered almost all over the body. He had excised a fresh papule, microscopical sections of which were exhibited. The sharply defined lesion in the cutis consisted of cell-infiltration.

(2) A patient, suffering from a pigmented, retiform, papular eruption, who had been exhibited at the last meeting of the Society, and at the request of the members he had had a drawing of the case made for

the Society's album. Since the last meeting portions of the pigmented lesions, as well as of the non-pigmented warty portions, had been excised, and it could be seen from the sections which were under the microscope that the disease was merely an intense form of Lichen planus. The pigmentation had disappeared from the warty portions which seemed to have been brought about by superficial infection with staphylococci. It would be remembered that this extraordinary eruption was seen after the patient had recovered from exfoliative dermatitis. It seemed probable, however, that the exfoliative dermatitis had itself been but a complication of a pre-existing and rapidly spreading lichen eruption.

Dr. GRAHAM LITTLE showed (1) a woman with circumscribed *Scleroderma* on the right leg, with a duration of two years, without any apparent change during that time. There was no history of injury to the part.

(2) A case of *Urticaria pigmentosa* of the macular type, and (3) one of the nodular type of the disease. In the latter case the tumours were very much larger when the patient was first seen than at present. Itching was not a prominent feature in either case.

(4) A child, the subject of *Urticaria bullosa*. Two days ago the bullæ were very pronounced, but they had now burst, and the case consequently had a different aspect. On the back some of the bullæ were of the size of small apples. The case had been to St. Mary's Hospital for something like three years; but he saw it for the first time a month ago. The child was kept in hospital three or four days; the urine was examined each day. There were no lesions at the time the child was taken in, but they came afterwards. There were very large bullæ, with raised plaques of urticaria in the neighbourhood. As a rule the appearance of the bullæ was preceded by a large red raised surface. The grouping of it was not exactly that of Dermatitis herpetiformis, which was a suggested diagnosis. He had had a picture of the case painted. The child was not having arsenic. The urea was enormously increased during the whole time she was in hospital. Professor Wright examined the blood, but found nothing particularly abnormal. The temperature had been but very little elevated.

(5) A girl with an eruption of *Tuberculides*. The child had a similar attack to the present one last March, which lasted some

months, but disappeared with the advent of summer. Now it was practically confined to the lower limbs. Dr. Colcott Fox's description of *Acne scrofulosorum* would quite fit the case. There were enlarged glands in the axillæ, in the neck, and in the groins; and the child was delicate. The lesions had a small necrosed centre, surrounded by a rather dark areola, and the circulation of the child was poor.

The PRESIDENT hoped that Dr. Little would allow a duplicate coloured drawing to be made for the Society's collection.

Dr. STAINER thought the fourth case described by Dr. Graham Little should be called *Erythema bullosum*. The eruption was a localised one, and there had been recurrent attacks. The disease, therefore, belonged to the *Erythema multiforme* group.

Dr. EDDOWES, speaking in reference to the boy shown by Dr. Little, said that he looked upon the case as one of *Erythema bullosum*. Of course, Dr. Little had seen more of the case than the other members of the Society present, and therefore, perhaps, he might have observed some unmistakable signs of urticaria present in the case, but Dr. Eddowes said that clear signs still existed of the more permanent condition of erythema—namely, redness, swelling and branny desquamation, the latter a sure sign that congestion had not been merely evanescent. The arc-shaped distribution of the erythematous area was similar to that seen in cases of extensive herpes zoster and supported the theory of its nerve-origin.

With regard to Dr. Little's last case, he looked upon it as essentially one of folliculitis—or acne necrogenica, a condition commonly seen in subjects rendered vulnerable by many causes such as tuberculosis, syphilis, alcoholism, &c.

Mr. HARTIGAN showed a young man (through the kindness of Mr. Waren Tay), aged 26, who for two years had had *tubercular Folliculitis* of the face. There were numerous small, reddish-brown papules, which, on pressure, showed "apple-jelly" nodules. There were also several scars. He had taken a piece of papule for microscopic examination, which he would be pleased to show at the next meeting of the Society.

Dr. NORMAN MEACHEN showed (1) a case of *local Hyperidrosis*. The patient, a boy aged 14, had come to the out-patient department at the Tottenham Hospital for pruritus of the body due to pediculi, when it was accidentally discovered that the tip of his nose was sweating. Further examination revealed a bilateral hyperidrosis involving the skin over the alæ nasi and the median line, though not extending as far as the nasal bones. The same area of integument was studded over with numerous small telangiectases. The

condition had been noticed for one year and was constant, being apparently uninfluenced by emotion or variations of temperature. He had no previous illnesses.

(2) *A Case for Diagnosis* (for Dr. ABRAHAM). A girl, aged 23, had been attending the West London Hospital for three years with Friedreich's ataxia, for which, three months ago, she had electricity applied. From that time spots appeared upon the back between the shoulders which caused considerable irritation. On January 6th, there were numerous reddish-brown, flat macules chiefly aggregated in the interscapular region. There were a few scratch-marks, and there was well-marked dermatographia. The hands were cold and congested. The rest of the skin was normal.

The PRESIDENT said that it was not impossible that some of the pigmentary staining on the chest might be due to the presence of the *Microsporon furfur*, as the patient admitted that the same undervest was worn continually day and night.

Mr. GEORGE PERNET showed (1) a private female patient, aged about 40, with long-standing and extensive *Lupus vulgaris* of the face. In early childhood she had had suppurating glands under the chin, which either broke down or had been incised, and the scars of which were present. The *Lupus vulgaris* no doubt originated from this. The face was affected from ear to ear along the borders and adjacent parts of the lower jaw, the ears and their neighbourhood being mainly affected. The interesting points about the case were, firstly, the marked hard swelling about the sides of the neck below the lower jaw, especially on the right side, the enlargement being due to the involvement *en masse*, as it were, of the lymphatic glands and surrounding tissues. About the right ear there was an ulcerated and crusted area. There was no enlargement of the glands in the axillæ, nor, according to the patient, in the inguinal regions. Secondly, there were four hard tumours about the forearms (two on each), well-defined, from half to one inch across, which could be better felt than seen. Two of them were slightly elevated above the level of the skin, the surface of which was not objectively involved. They were neither painful nor tender, and were movable over the subjacent tissues. Mr. Pernet considered they came into the category of tuberculo-gummata. They were not lipomata. They had been present, according to the patient, for some years (three or

four), and she had not noticed any change in them. It should be added that the patient was well nourished and her general health was excellent, which might account for the chronicity of the tumours.

Dr. LESLIE ROBERTS, who was present, agreed with Mr. Pernet that the tumours were not lipomata. He agreed also as to their tuberculous nature. This is mentioned with his permission.

The PRESIDENT regarded the nodular conditions as lipomatous, their long duration being in favour of that view. He thought that if they were of tubercular nature they would have ulcerated, or undergone some degree of absorption.

Mr. HITCHINS regarded the lumps in the forearms as lipomata; he did not agree that there was any tubercular element about them; moreover, there appeared not to have been anything like erythema or induration in connection with them.

Dr. A. J. HARRISON asked whether there was any "apple-jelly" deposit in the so-called lupus. Looking at the skin-tumours from the point of view of the glandular enlargements, he inclined to the belief that they were tubercular.

(2) Finger-nail scrapings (in a solution of potash) from *Tinea unguium* as it occurred in Iceland, where these nails are called Kart-neglür (from Kart = card, for combing out wool, and neglür = nails). Professor Ehlers, of Copenhagen, had demonstrated their parasitic nature. According to him, the disease was contracted from sheep, and one or two out of every ten peasants in Iceland suffered from it. The specimen exhibited showed the mycelium, which in some preparations was very abundant, especially in scrapings from the under surface of the nails. Mr. Pernet hoped to show some cultivations on a future occasion. He was indebted for his material to Dr. Bjarnhjedinnsson, of Reykjavik, who had also sent him some wool from sheep suffering from *Scabies ovina*. Mr. Pernet had not found fungus in the wool.

Dr. SAVILL exhibited two cases for the purpose of showing the course through which localised sclerodermia or *morphæa* passed, and also illustrating the identity, as he believed, between *morphæa* and facial hemiatrophy. He thought, also, that the cases threw some light on the pathology of the affection. The first patient was a woman, aged 51, who for eight years had had a patch at the lower edge of the costal margin, just below the left breast. He saw her soon after it first appeared, when it presented the typical white ivory appearance with the violet blush surrounding it: a thick fibroid patch, and remained so for some years afterwards. But in the course of eight years it had undergone the transformation

which he believed always took place. He thought the varieties of the disease were only phases of the same process (*e.g.*, *morphœa lardacea* and *morphœa atrophica*). At present there was nothing to show except atrophy of the skin, only just visible to the naked eye.

The second case was that of a man aged 50, a waiter by occupation, who had well-marked *facial Hemiatrophy* on the right side. He showed the case at the last meeting of the Clinical Society of London, with sections of the skin. In the year 1882 the patient struck the top of his head when running upstairs. Two or three years afterwards he noticed that the hair was coming off his head and eyebrows, and the left side of his face was becoming thin. Much pain was felt on that side, but it yielded to remedies. There had been progressive atrophy on the right side of the face, roughly corresponding to the distribution of the fifth cranial nerve. The atrophy involved the subcutaneous tissue as well as the skin. He also had patches of atrophic skin, just like those in the first case, on different parts of his body. A thin patch on the back presented some pigmentation and telangiectasis; there was a patch on the outer side of one knee, and thinning of the skin behind the ears. The history pointed to the existence of a neurotrophic lesion. Recently an affection of the eye had supervened, which Dr. Savill's colleague, Mr. Work Dodd, declared to be of a trophic character; there was congestion of the conjunctiva, and the cornea was abraided. There was no loss of consciousness at the time of the accident, but a depressed scar at the point of injury.

Mr. ARTHUR SHILLITOE showed (1) a case of *varioliiform Syphilide*. The patient, aged 42, acquired syphilis early in October last. He was an in-patient at the Lock Hospital with chancre, roseola, etc., from November 13th to December 22nd. At the beginning of the year he attended the out-patient department, when his face was seen to be thickly scarred with small-pox, from which he had suffered some thirty-six years previously. The syphilis being fairly quiescent the treatment was continued. One week later, each variola scar was the seat of a hard, deep red, smooth papule about the size of a swan shot, and the left eyelids were so swollen that he could scarcely use the eye. The variola scars on the covered parts of the body were not nearly

so universally affected as were those on the forehead and face. Under iodides he is very rapidly improving. The papules are flattening, without becoming either pustular or umbilicated.

The PRESIDENT said it much resembled a case he had had under care (a coloured drawing of which he exhibited to the Society) of a man who obtained no treatment for his primary disease, and who developed a huge papulo-tubercular eruption upon the face a few months afterwards.

(2) *Lichen planus*. C. M., aged 22, had intercourse early in October, and the very next day noticed two places on the glans. November 12th, having had no treatment, he attended out-patients, showing two large smooth violaceous plaques on the dorsal aspect of the corona, and extending over the glans penis. At the umbilicus were a few small papules. The flexor surfaces of the forearms and extensor surfaces of the legs were the seat of an extensive red, very irritable papular eruption. Each papule on the forearm was deeply pitted, as though a central core had been extruded. On the legs the papules had undergone some involution, and were no longer discrete. There were a few small white streaky patches on the mucous membrane of the cheeks. Remembering how often *Lichen planus* suddenly appears after any nervous shock, Mr. Shillitoe suggested that the cause might be looked for, in this case, in the intercourse which took place early in October.

Dr. WILFRID WARDE showed a male patient, aged 68, suffering from extensive *Lupus vulgaris* of face, neck, and scalp. The disease commenced twenty-four years ago as a small patch on one cheek, and remained thus limited for sixteen years. Then it extended over the greater part of face and scalp. At the present time nearly the whole scalp and face were involved, the centre of chin, part of forehead, and an area over the occiput being the only unaffected parts. The disease also extends round the neck as a band from 2 to 3 inches wide. The cartilage of the left ear is destroyed, but the other cartilages seem singularly immune, and this is probably due to the late onset of the disease.

REVIEWS.

DISEASES OF THE SKIN.*

DR. RADCLIFFE-CROCKER'S "Diseases of the Skin" is a text-book which is now so well known to the medical world that any reference to its scope and general arrangement is rendered wholly unnecessary. It is the recognised English text-book on the subject, and one that we have reason to be proud of. For more than a year we have been looking forward to the publication of this new edition, and now that this has been accomplished we offer our hearty congratulations to the author, for the reality has quite fulfilled our warranted expectations.

It is ten years since the last edition of the book was issued, and during that time much valuable work has been done in dermatology; new diseases, such as blastomycetic Dermatitis, have been added to it; the pathology of a large number of cutaneous affections has been more fully worked out; and new methods of treatment, such as by the Röntgen rays and the Finsen light, have been devised. For these reasons, apart from the fact that the second edition has been out of print for several years, a new edition of the book was almost a necessity.

The text-book appears in a somewhat new garb. In the first place it has been divided into two volumes of about 700 pages each, and nearly 500 pages of letter-press have been added to it since its last issue. The first volume contains the congestions, inflammations, hæmorrhages, hypertrophies, pigmentations, atrophies and neuroses of the skin, while the second includes the neoplasms, the diseases of the skin-appendages, the diseases due to fungi and animal parasites, and the appendix. The volumes are handy in size and not too heavy, and both the printing and the paper are all that could be desired.

No radical change has been made in the arrangement of the book; it has simply been amplified to bring it thoroughly up-to-date and several new illustrations have been added. A large number of new subjects have been discussed at greater or less length, and a brief reference to these will be of interest. Among them is Acrodermatitis perstans (Hallopeau), a disease which is closely allied to Dermatitis repens, and of which cases have been published by Hallopeau, Audry, Frèche and Stowers. Cheilitis exfoliativa (Psoriasis labialis, of Bateman) is also referred to, and its differential diagnosis from ordinary eczema of the lips is discussed. In opposition to Besnier's view that this affection is closely allied to seborrhœa of the face and scalp, the writer points out that in his own case, and in the one reported by Jamieson no seborrhœa was present. Lichen variegatus, as the author prefers to call Parakeratosis variegata of Unna, is described, and a reference is made to the recent observations and reported cases of it. The author adopts the suggestion of Fox and MacLeod to include under one group the following resistant scaly affections: Parakeratosis variegata (Unna), Erythrodermie pityriasique en plaques disséminées (Brocq), Dermatitis psoriasiformis nodularis, Pityriasis lichenoides

* *Diseases of the Skin*. By H. Radcliffe-Crocker. Third Edition, 2 vols. (London: H. K. Lewis. Price 28s. net.)

chronica (Juliusberg), and the Psoriasiform and lichenoid exanthem of Neisser and Jadassohn, but goes further than these writers and regards all these affections as synonymous with *Lichen variegatus*. That these affections are closely allied, and belong to one group, there can be little doubt; but the assertion that they are all the same disease, or different phases of one entity, has yet to be proved, and is somewhat premature and possibly erroneous. In contradistinction to this endeavour to simplify, we have a hard and fast line drawn between the rare affection which Galloway described in 1899 under the heading of *Lichen annularis*, and the closely allied if not identical condition which the author has named *Granuloma annulare*, and of which cases have been recognised and exhibited also by Pernet, Pringle and Sequeira. It seems to us to be somewhat inconsistent to insist on re-christening *Parakeratosis variegata*, *Lichen variegatus*, although the degree of parakeratosis may be negligible, and then to adopt a purely histological title like *Granuloma annulare* for a serviceable clinical name like *Lichen annularis*, since the latter is far more closely allied to the former than several of the conditions which are classed by the author as synonymous with *Parakeratosis variegata*. It seems to us that unless a complete new terminology be adopted, perhaps on the lines of Philippson's proposed "Reform in Dermatology," it were better to avoid making an already complex nomenclature more so.

Under the heading of "Dissection wounds" a description of "Gayle" in man is added in this edition. In the lambing season ewes are liable to a very fatal disease called "Gayle," which appears to be a sort of puerperal fever. Men who skin animals which have died of this disease sometimes inoculate their hands. This causes a local lesion of the nature of a lobulated vesicle containing blood-stained serum, and surrounded by a slight areola. Klein has shown it to be due to the "*Staphylococcus hæmorrhagicus*."

The mysterious affection described by Mibelli as "*Porokeratosis*" is also referred to. The name was given to it because it was supposed to be a hyperkeratosis of the mouth of the sweat-follicles, but this has yet to be proved, and as the author points out, both Ducrey and Respighi have shown that the mucous membrane where no sweat-glands exist may be affected. Still, it is an interesting fact that it is generally worse in summer, when the sweat-secretion is more active, than in winter. Respighi described the same affection almost simultaneously as "*Hyperkeratosis eccentrica*." We would have preferred the adoption of the latter name, as Mibelli's title is a confusing one, and cannot be said to do more than suggest the nature of the affection it is meant to indicate. Again we note the nomenclature with regard to *Acanthosis nigricans*. The writer has avoided the original name given to it by Pollitzer and Janowsky, and has adopted instead the title given to it by Kaposi—namely, *Keratosis nigricans*, because "it represents a clinical fact instead of an incorrect pathological theory, and brings it into line with the other keratoses." This change of title we take exception to, for if a histological name is to be used at all—and we regard keratosis more as a histological than a clinical designation—why not adhere to the name which describes the most obvious histological change present—namely, *acanthosis*; in this affection the keratosis is comparatively slight compared with the proliferation of the Malpighian layer. On the other hand we are at one with the author in changing the former name of *Hydroa herpetiforme* to the more usual one of *Dermatitis herpetiformis*. We are not convinced, however, that the substitution

of the title *Lichen acuminatus* for the *Pityriasis rubra pilaris* of Devergie is an advantage.

In the second volume a careful description of *Acne agminata* is given and a plate illustrating the author's own case. He believes that the disease is identical with Barthélemy's *acnitis*, but not with *folliclis*. Recently other cases of this rare condition, first described by Tilbury Fox, have been shown at the Dermatological Society of London by Perry and Galloway.

With regard to the vexed question of the so-called seborrhoic affections, the author has employed the convenient French heading of *Seborrhoïdes*, under which he groups Seborrhoic dermatitis (unfortunately spelt *seborrhœic*), *Seborrhœa eczemaformis* (*Lichen simplex* of Vidal), *Seborrhœa psoriasiformis*, *Seborrhœa papulosa seu lichenoides* (Flannel-rash). It is a convenient grouping, and, until more light is thrown on the pathology of these affections, will prove of undoubted value. As was to be expected, the subject of Blastomycosis, which has now been made so familiar by the writings of Gilchrist, Hyde, Montgomery and others, is briefly but adequately discussed.

Among the other new subjects dealt with in this edition are persistent Balanitis, *Erythema serpens*, *Erythema elevatum diutinum*, X-ray dermatitis, Toxin serum eruptions, Bronzing of the Skin in Diabetes, *Keratolysis exfoliativa congenita* (Sangster), *Mal de Meleda*, *Granuloma inguinale tropicum*, *Granuloma pyogenicum*, Sarcoid, *Pseudo-xanthoma elasticum*, Leukæmia and *Pseudo-leukæmia cutis*, Chloroma, *Endothelioma capitis*, Veld sore, Hydrocystoma, *Milium congenitale*, *Acne necrotisans*, *Alopecia cicatrisata*, and *Folliculitis decalvans*.

The pathology and histology of many of the diseases described in the former edition have been greatly amplified in the "light of recent research." With regard to the streptococcic origin of *Impetigo contagiosa*, the writer points out that before it can be definitely decided only fluid from unruptured vesicles must be used, and liquid media employed, and considers that "to continue to make observations on fluid from beneath crusts is so obviously open to error as to be unscientific and waste of time." The pathology of *Urticaria pigmentosa* is referred to, with a special note of the work of Unna, Gilchrist and Brongersma on the accumulation of mast-cells in the cutis, and their significance. The subject of *Herpes zoster* is discussed at considerable length, and two diagrams are added showing the areas occupied by the eruption. These are reproduced from the classical article of Head and Campbell which appeared in "Brain" in 1900. The author agrees that on the whole "the evidence points to the eruption of idiopathic zoster being due to a toxic inflammation of the posterior root ganglion of the nerve-area affected," but considers that it may be produced "by any irritative lesion or condition in any part of the tract from the cord to the periphery of the nerve supplying the affected skin."

With regard to Yaws, the writer holds the position that it is a different disease from Syphilis, and mentions the various clinical distinctions between the two diseases, quoting at length from MacLeod's histological description of the disease. The pathology of *Erythema induratum* is also discussed, and special reference is made to Whitfield's view that two distinct affections are included under the title, an opinion which had been previously stated by Galloway.

The subject of the treatment of skin diseases has been comparatively slightly changed, with the main exception of the addition of a description of treatment by

means of the X-rays and the Finsen light. The author strongly advocates the employment of "high tubes," with a spark-gap of six inches at least in the treatment of cutaneous affections.

Several new illustrations have been added, such as a coloured plate showing the more common syphilides, and two plates of ringworm fungi, as well as impressions in the text from a number of process blocks.

The appendix has been amplified by the addition of a useful table of subcutaneous and intra-muscular injections, including such substances as thiosinamin and Coley's fluid, and a short section on the clinical examination and staining of bacilli and fungi by Mr. George Pernet.

This all too short review, considering the importance of its object, will serve to show the thoroughness with which the revision of the text-book has been carried out, and we again offer our warm congratulations to the author for having given us in this new edition so clear an indication of the progress of dermatology in the last decade.

LANG'S THERAPEUTIK FÜR VENERISCHE UND HAUTKRANKE.*

THIS small volume of about 200 pages is well known to the students at the Allgemeine Krankenhaus in Vienna, and its popularity is made evident by the fact that it has now reached its fourth edition. Though of comparatively limited interest to the general dermatological world, as it is essentially a ready reference handbook for Professor Lang's own students, still the teaching of so distinguished a worker commands more than a passing notice. It is of interest to note that Professor Lang has now almost abandoned excision of the initial chancre in syphilis, and considers that it is useless unless in the earliest stage of the lesion, before the glands become affected, and in cases where the chancre is perfectly demarcated, and that even then its value is doubtful. Inunction appears to be his favourite method of treatment with mercury. It strikes us that he has been singularly fortunate in his results in the local treatment of Lupus erythematosus when it is stated that many of the cases heal under either salicylic soap plaster or mercurial plaster.

With regard to Lupus vulgaris, he still maintains that the best treatment, where practicable, is total excision followed by grafting, the graft being cut to include the whole of the skin and the upper portion of the subcutaneous tissue, and not simply the epidermis as in Thiersch grafting.

CURRENT LITERATURE.

A CASE OF GENERAL HYPERIDROSIS. G. AMENTA. (*Gas. d. ospedali e d. cliniche*, June 29th.)

A CASE is described in a man 20 years of age, where the onset of general hyperidrosis was considered to be due to excitation of the sweat-centre in the

* *Lang's Therapeutik für Venerische und Hautkranke*. By Ed. Deutsch. (Vienna: Josef Sáfár. 1908. Fourth edition.)

cord, either by the toxins of syphilis, or directly by some syphilitic inflammatory lesion. The patient was suffering from secondary syphilis and had had a short course of mercurial treatment, when he developed indefinite pains in the legs, worse at night, and generalised pruritus. This was followed by a tendency to perspire copiously over the whole surface of the body, the perspiration being unpleasantly abundant, but free from any marked odour or colour. The quantity secreted increased gradually in spite of treatment, which was varied from time to time without success. Hypodermic injections of atropine, strychnine, quinine and agaricine were found to be useless, and it was thought inadvisable to push either strychnine or agaricine, since even small doses of these drugs gave rise to marked toxic effects. Large doses of potassium iodide, arsenic, morphine, and various methods of administering mercury were tried, but had to be abandoned, nor did friction of the skin with alcohol and tannic acid, cold baths or hypnotism meet with greater success. In the end the hyperidrosis ceased after a few days' inunction of oil of almonds, but the author did not think that the cure was to be ascribed to the oil, but rather was an accidental coincidence.

J. L. BUNCH.

QUARTERLY SURVEY OF DERMATOLOGICAL LITERATURE.

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- Dermatitis Pyæmica**. L. MERK. (*Archiv f. Derm. u. Syph.*, December, 1902, p. 253. One Plate.)
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- Eczematoid Dermatitis**, An Infectious Form of. MARTIN F. ENGMAN. (*American Medicine*, November 16, 1902, p. 769.)
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PLATE I.

DR. SEQUEIRA'S CASE OF BLASTOMYCOSIS.

PLATE II.

FIG. 1.

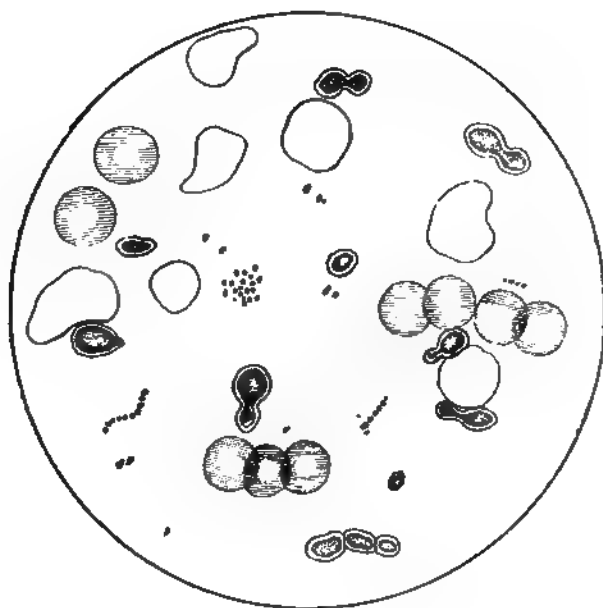


FIG. 2.

DR SEQUEIRA'S CASE OF BLASTOMYCOSIS.

THE BRITISH JOURNAL OF DERMATOLOGY.

APRIL, 1903.

A CASE OF BLASTOMYCOSIS.

By JAMES H. SEQUEIRA, M.D. LOND., M.R.C.P. LOND., F.R.C.S. ENG.,
Assistant Physician to the Skin Department of the London Hospital.

BLASTOMYCETIC DERMATITIS was the subject of a demonstration by Professor Gilchrist at the Annual Meeting of the British Medical Association last August, and it is to that demonstration that I am indebted for the recognition of the case I am about to describe, and which I believe to be the first recorded in this country. In some details my case differs from those described by Gilchrist, Hyde, Montgomery and other American workers, and it is possible that the organism found, though a blastomyces, may be a different species. I was, unfortunately, unable to get cultures, but the essential features of the lesions, both macroscopically and microscopically, and of the organism, leave no doubt in my mind that my case is of the same nature as those described in America.

The patient, a strong healthy man, aged 37 years, was sent to me by Dr. Larder, the Medical Superintendent of the Whitechapel Infirmary, in October, 1902. He was born in Staffordshire, and had never resided out of England. He had been employed at a brewery, but for some years had been engaged as a farm labourer, but was never long in one employment. He had had a good deal to do with cattle, and especially with pigs, and he described himself as having a local reputation as a "pig doctor." He was unable to recall any instance of any peculiar disease affecting the animals he was looking after.

The patient was a thriftless man, and found his way to London, where it seems that he had been in several casual wards, and eventually he came into the Whitechapel Infirmary, whence he was sent to me.

Family History.—His father died at the age of 81, it is said from phthisis. His mother is alive and well; her age is 78. One brother and five sisters are alive and in good health. One sister died at the age of 28, but there are no details as to the cause of her death.

The patient is unmarried. There is no history or evidence of syphilis. He had enjoyed good health until the spring of 1901, when a small white spot the size of a pin's head appeared below the inner canthus of the left eye. This increased and spread inwards, and at the end of three months it was as large as a sixpenny-piece. At times there was a whitish offensive discharge from it, and occasionally there was slight hæmorrhage when the spot was rubbed. There was considerable itching, and this caused the patient to scratch it and set up bleeding. About five months after the first spot appeared an exactly similar lesion was noticed below the right eye, and this progressed in the same manner, gradually enlarging, until the lower lid was so much swollen that vision was somewhat impaired, and there was constant epiphora. Several small spots appeared at intervals around the original lesions and on both cheeks, and one also upon the scalp.

The condition when the patient was admitted to the hospital is well shown in the plate (Fig. 1), which is reproduced from a photograph taken from a water-colour drawing made by Miss Mabel Green.

Below the lower eyelid, on the left side, there was a slightly raised irregular swelling covered with a thin yellow-brown crust. The margin of the lid was quite free except at the inner canthus. The swelling was an inch long and rather more than half an inch broad. It was freely movable over the subjacent tissues, and there was no infiltration around it. It was not tender or painful, but was said to itch. On pressure a thin, whitish, somewhat offensive discharge could be squeezed from under the crust. On removal of the crust the surface of the tumour was found to be slightly ulcerated, and the thin discharge could be squeezed out of the small ulcers.

On the right side there was a similar, but larger, irregular

swelling, with a raised margin and irregular surface. This was sometimes covered with a scab, but when the drawing was made it was free from crust. Pus could also be squeezed out from this tumour.

Around the eyes and on the cheeks, just below the eyelids, there were several smaller lesions. Some of the smallest were whitish, but the larger spots were brown or reddish in colour. The patient said that the larger swellings resembled these at their first appearance. There was also a small tumour, about the size of a filbert-nut, upon the scalp near the middle line. From all of the larger swellings a thin purulent discharge could be squeezed out. The skin elsewhere was quite free from disease. There was no evidence of disease of any of the viscera.

The patient was shown at the Dermatological Society of London at the November Meeting (*Brit. Journ. of Dermat.*, 1902, XIV., p. 469), and the members present agreed that the case was quite exceptional in its appearance. At the same time a stained specimen of the pus squeezed out from one of the tumours was exhibited, and this showed the presence of yeast-like bodies. A portion of one of the tumours was removed for microscopical examination.

Iodide of potassium was given in five and then in ten grain doses three times a day, but there was little improvement until the drug was pushed. When the dose had been increased to 105 grains a day a marked diminution in the size of the lesions was noticed, and many of the small spots cleared up entirely. Ultimately the mass under the left eye almost completely disappeared, and the area under the right eye was less than half the original size. The patient then became restless and determined to leave the hospital. Endeavours were made to keep him under observation, but without avail.

Microscopical Appearances of the Excised Tumour.—The mass of the growth is seen to be formed by a great increase in the epidermal layers. The horny layer is somewhat thickened in parts, and in the epidermis there are numerous small abscesses. In the section figured several small abscess cavities are shown (Fig. 1). The deep layers of the epidermis are thickened and there are numerous downgrowths into the corium, some of the downgrowths branching into finger-like processes. Under a high power, these branching downgrowths are found to consist in great part of prickles, the outline of the prickles

being particularly well marked. No cell-nests were found. There is a considerable infiltration of round cells. In the abscess cavities some of the yeast-like bodies are visible. In some of the sections giant-cells are seen, but I was unable to detect any of the organisms in them. No tubercle bacilli were found in any of the sections.

The pus squeezed out from one of the growths contained pus-cells, a few eosinophiles, some erythrocytes, a large number of cocci, and yeast-like bodies. These bodies are ovoid, and have a well-defined margin and double contour. They vary in size from three to five micro-millimetres. They are seen as single organisms and in pairs, and in many instances as unequal pairs. In some the formation of buds is well seen, and in two or three instances three cells form a short chain. Fig. 2 is from a drawing made to scale showing the various stages observed in the specimen. The organisms stain well with hæmatoxylin.

The only difficulty in the case is that my colleague Dr. Bulloch was unable to cultivate the organism. This I believe is due to the fact that we examined lesions which were already infected with cocci. Dr. Montgomery informs me that he makes his cultures from lesions which are only visible under a magnifying glass, and I regret that I was unable to keep the patient under observation long enough to have learned this point in the technique. Another point is that the organism found in my case is much smaller than that found in the American ones. The bodies in my case were nearly always from three to five micro-millimetres in size, while the organism described in America varies from seven to twenty micro-millimetres, but in one of the cases described by Montgomery there were mixed with the larger organisms bodies which were only 3.75 micro-millimetres in length.

The clinical appearances and the results of pathological examination exclude rodent ulcer, epithelioma, and other neoplasms of the skin, and also lupus and other granulomata.

I base the diagnosis of blastomycosis upon the following points:—
(1) The face and scalp alone were affected. (2) The lesions were multiple. (3) These spread and fresh lesions appeared apparently by inoculation. (4) The edges of the tumours were well defined and there was but little infiltration. (5) They soon became pustular, and thin whitish pus could be squeezed from the lesions. (6) Microscopically there were numerous minute epidermal abscesses. (7) In

these abscesses and in the pus squeezed from them budding yeast-like organisms were found. (8) From the deeper layer of the epidermis branching downgrowths of prickle-cells were found extending into the corium. (9) The growths were markedly influenced, but were not entirely dispersed by iodide of potassium in large doses.

I have to acknowledge the valuable assistance rendered me in the investigation of the case by Mr. Balean and by Dr. Bulloch.

DESCRIPTION OF PLATES.

PLATE I.

Photograph of a drawing of the patient, showing granulomatous papules below the lower eyelids, the left one being covered with scab; also small nodular lesions on the cheek and right upper lid.

PLATE II.

FIG. 1.—Section of one of the small tumours. It shows the irregular proliferation and downgrowth of the epidermis and the characteristic epidermal abscesses.

FIG. 2.—Drawing of the budding organism.

PHARMACEUTICAL NOTES.

By HERBERT SKINNER,

Pharmacist to the Great Northern Central Hospital.

In some notes written for the Journal three years ago there is a formula for a combination of iodine and oleic acid. It was rather an unhappy one, as decomposition usually set in within a few days, yielding an unpleasing product. Since then much attention has been bestowed upon iodine and oleic acid preparations. The advantage of these over alcoholic solutions of iodine lies in their non-staining properties and their capacity of being better absorbed. The presence of a non-drying diluent will allow the preparation to be rubbed into the skin until no trace of colour is left, even in the case of a 10 per cent. solution; and the stain resulting from a 20 per cent. solution, or even a stronger one, will yield to soap and water when necessary.

A certain amount of combination takes place, therefore these solutions are always stronger than those of the Pharmacopœia.

Iodine is very soluble in oleic acid, which thus replaces potassium iodide. If after triturating the two together a small quantity of ammonia is added, a soapy paste results which is soluble in all liquids save fixed oils, though miscible with oleum paraffinum album. To demonstrate its solubility the following formula was made up about four months ago and is still as good as when first prepared:—

Iodi Resublimat.	.	.	.	½ oz.
Ac. Oleic.	.	.	.	½ fl. oz.
Alcohol	.	.	.	8 fl. drms.
Liq. Ammon. Fort.	.	.	.	1 fl. drm.

It is too strong for most purposes, but I fancy it could be made even stronger, and so rival the 50 per cent. solution in Acetone, which changes within a short time, and produces a stain which is immovable for days.

Paraffinum Iodi is made on the same principle as the preceding:—

Iodi Resublimat.	.	.	.	1 oz.
Ac. Oleic.	.	.	.	2 fl. ozs.
Liq. Ammon. Fort.	.	.	.	8 fl. drms.
Ol. Paraffin. Alb.	.	.	.	ad 1 pint.

This is our hospital formula which has been used for the last three years, apparently giving uniform satisfaction, and has now almost ousted the alcoholic solutions. The iodine is triturated with the acid, ammonia added, and finally the oil.

There are two useful oleates—potassium and ammonium. In all save the iodine preparations the former is preferable. In the succeeding formulæ it will be simpler to speak of these in solutions.

Ammonium oleate is prepared according to the following formula:—

Ac. Oleic.	.	.	.	4 fl. ozs.
Alcoholic Ammonia	.	.	.	1 in 8 a sufficiency.

The solution is slowly added, well shaking meanwhile, until only a faint odour of ammonia is present.

The solution of potassium oleate is taken from the solutio saponis æthereæ of Mr. White of St. Thomas' Hospital. Leaving out the æther:—

Ac. Oleic.	.	.	.	7 fl. ozs.
Alcohol	.	.	.	8 fl. ozs.

Neutralise with a solution of potassium hydrate 1 in 1, using phenol phthalein as an indicator.

The solutions of potassium oleate are not suitable for iodine preparations as they combine too readily. The following becomes colourless within two days :—

Iodi Resublimat.	.	.	.	$\frac{1}{2}$ oz.
Sol. Potass. Oleat.	.	.	.	2 fl. ozs.
Glycerin .	.	.	.	4 fl. ozs.
Aq. Dest.	.	.	.	ad 1 pint.

It is not so with ammonium. The paraffinum iodi has been largely used for internal administration ; and speaking from a dispensing point of view, paraffin is not a nice thing to add to an ordinary mixture. The claim for more rapid assimilation appears to me to be due to the oleate, therefore a much better preparation, using ammonium, can be made :—

Sol. Ammon. Oleat.	.	.	.	1 fl. oz.
Iodi Resublimat.	.	.	.	1 oz.
Alcohol .	.	.	.	5 fl. ozs.
Glycerin .	.	.	.	ad 1 pint.

Strange to say, this formula yields a better result for external use than the paraffin. iodi. The iodine is absorbed in about half the time, and glycerin can be wiped off after the colour has disappeared. It is quite as non-drying as the oil.

These are the only preparations with ammonium. In every other case potassium is better because of the certainty of neutrality. A soap will nearly always improve a fatty base, and a thick fluid product like solution potassium oleate is the ideal way of mixing a soap with a base.

Wool fat and soft paraffin are the two most amenable to modification and improvement. Equal parts of potassium oleate and wool fat will take up their own weight of liquid and remain as a permanent creamy fluid. With soft paraffin the average proportion will be one drachm to the ounce for an ordinary base.

In many cases the oleate may replace *sapo mollis*, giving an improved product.

Picis. Liquid.				
Sol. Potass. Oleat.	.	.	.	equal parts.

This allows the tar to be entirely rubbed into the skin. It is a liquid and leaves no tarry stain behind, and is washable and non-sticky.

Sapo camphoræ co. is a favourite soap, and may be modified into an ointment.

Sulph. Præcip.	.	.	.	2 drms.
Camphor	.	.	.	1 drm.
Bals. Peru.	.	.	.	2 drms.
Sol. Potass. Oleat.	.	.	.	8 ozs.
Adeps. Lanæ. Hydros.	.	.	.	$\frac{1}{2}$ oz.
Aq. Dest.	.	.	.	$\frac{1}{2}$ fl. oz.

It is semi-solid and may be used as a soap with water.

There is one more preparation against which failure seems to have been written. It may be due to the unsuitable bases with which it is generally mixed. Formaldehyde is very elusive with a fatty base or as an ordinary solution, it really requires something to fix it in order to bring out its best qualities. For this purpose, nothing is better than soap, and a liquid one answers best of all.

Formalin				
Sol. Potass. Oleat.	.	.	.	of each 2 fl. ozs.
Glycerin	.	.	.	$\frac{1}{2}$ fl. oz.

It is a very powerful caustic and for an ordinary wash is far too strong. The quantities may be varied at will. A useful liquid anti-septic is made on the same basis.

Formalin				
Glycerin	.	.	.	aa $\frac{1}{2}$ fl. oz.
Sol. Potass. Oleat.	.	.	.	8 fl. ozs.
Ol. Lavand.	.	.	.	20 minims.

This produces no deleterious effect upon the skin, and is nevertheless a powerful germicide.

The preceding formulæ will demonstrate the possibilities of a liquid soap. Liniments containing "sapo mollis" are not improved by it in any way. The main feature to bear in mind in prescribing a combination with it, is that it is a soap, and therefore incompatible with acids and easily reducible bodies like pyrogallol and resorcin.

In connection with the latter salt and in answer to a few inquiries, a vaselin resorcin can be made on a ceratum galeni basis, which will remain unchanged any length of time, providing it does not undergo undue exposure.

Cera. Alb.	.	.	.	.	1½ ozs.
Cetaceum	.	.	.	.	1 oz.
Vaselin	.	.	.	.	4 ozs.
Ol. Olivæ	.	.	.	.	5 fl. ozs.

Solve, then add slowly, stirring continuously, the solution containing

Resorcin	.	.	.	.	2 ozs.
Aq. Dest.	.	.	.	.	2½ fl. ozs.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of this Society was held on Wednesday, March 11th, 1903, Dr. J. J. PRINGLE in the Chair.

The following cases and specimens were shown :—

Mr. WILLMOTT EVANS showed a case of *Pityriasis rubra pilaris* (Devergie). The patient was a well-nourished woman aged 56 years. There was nothing of importance in her history. About three years ago she had some scaliness of the scalp which extended over her forehead, but this lasted only three weeks and disappeared without treatment. In August, 1902, her forehead became rough, and this roughness gradually spread to the face and neck, and to the arms and trunk. Her condition when shown was as follows :—

On the front of the chest, the abdomen and the lower half of the back the skin is thickly studded with sharply-pointed papules, each representing a hair-follicle. The more recent papules are discrete, but where the eruption is of longer duration the whole surface is covered by scales, which come away freely. This scaliness is most marked on the thighs and knees and in the inter-gluteal groove. The flexor surfaces of the arms show the acuminate papules, but on the extensor surface the scaliness is well marked, and a shagreen-like surface is produced by the heaping-up of the scales on the papules. The epithelium of the palms and soles is much thickened and cracked, and the nails are raised from their beds by a mass of ill-formed keratin. The face is comparatively free, but the scalp is very scaly and the hair is somewhat scanty. The patient says that

the hair nearly all came off soon after the commencement of the illness and that the present hair is a fresh crop. The subjective symptoms are slight, there is some irritation, and she complains of a feeling of depression.

Dr. COLCOTT FOX presented a labourer, aged 32 years, of fine physique, suffering from a sparsely disseminated, generalised, secondary *syphilitic eruption* of the skin and mouth. The initial lesion on the penis had only recently disappeared. The interest of the case consisted in the large size of the elements, which ranged from a split pea upwards, but were mostly the size of a shilling and were unusually massive, simulating late nodular or gummatous lesions. The elements were papules, and though so bulky seemed to involve only the superficial layers of the dermis. When first seen the elements were all pustular, and the exhibitor had a portrait taken of the eruption as an example of the ecthymatous syphilide, but under the influence of mercury internally all pus-formation had disappeared, though the bulky masses of syphilitic formation resolved but slowly.

Dr. JAMES GALLOWAY presented a very characteristic case of *Urticaria pigmentosa* in a boy aged 2 years. The eruption had been noticed by the mother a few days after birth. She describes the spots as they appeared at that time as being pinker in colour than they are now, and there appears to have been a distinctly pomphoid period in the eruption. The lesions now are very numerous and scattered over the whole of the body and extremities, the face being unaffected. They are characterised by a profusion of brownish pigmentation involving and surrounding the papular elevations, which may be as much as one or two centimetres in diameter. The actual elevated area shows a slight difference in the texture of the skin, as well as of its colour. The follicles of the skin are more pronounced, so that its aspect is something like that of the skin of a Tangerine orange.

In addition to the pigmentation seen in the actual lesions, there is to be noticed, on what appears to be otherwise normal skin, a large amount of faint pigmentation as if a weak sepia wash had been applied to the surface in circinate areas with a brush. This appear-

ance was more noticeable in the case shown than in most others of this disease.

A good deal of pruritus is apparently suffered by the child, although there are almost no signs of scratching. Factitious urticaria can be excited without much difficulty when the papular lesions especially manifest the characteristic reaction.

The members present regarded the case as a striking example of the disease.

Mr. MALCOLM MORRIS stated as his experience that patients suffering from this malady usually suffered from pruritus, sometimes very severely; but that in spite of this fact, they very rarely produced damage to the skin by scratching. There seemed to be some reason, possibly on account of the ease with which the skin is injured, which prevented the usual results of pruritus in children.

Dr. J. M. H. MACLEOD showed (1) a patient suffering from a peculiar affection of the nose resulting from a localised hyperidrosis, to which Jadassohn has given the title of *Granulosis rubra nasi*.

The patient was a nervous delicate boy, aged 6 years, with a weak peripheral circulation. He perspired profusely on the slightest exertion, the hyperidrosis being most marked on the hands and the tip of the nose and the centre of the upper lip. On the nose there was a faintly red patch extending from the bridge of the nose to the tip and at the sides to the middle of the alæ. This faded gradually into the surrounding skin. The patch had a damp, glistening appearance due to the presence of small beads of perspiration, and it was dotted over with reddish-brown specks and small papules, the largest of which were about the size of a pin's head. These minute lesions were irregularly distributed and showed no tendency to become confluent. Pressure with a diascopé caused them to disappear, leaving no brown staining. There were no telangiectases or atrophic lesions present. This affection of the nose had begun when the boy was six months old, and had persisted without much alteration in spite of treatment. It is said to be aggravated in hot weather. The sweat on the nose gave a faintly alkaline reaction with litmus-paper. Unfortunately a biopsy was not obtained, but as the case corresponds clinically in every detail to those described by Jadassohn and Pick, the histological picture would doubtless be similar. Their cases showed that the pathological changes were confined to the sweat-apparatus and that the ducts were dilated and surrounded by an inflammatory infiltration of cells (peri-syringitis).

(2) A case of *unilateral nevus* in a boy aged 11 years. The lesion was of the linear type and was situated on the front and inner surface of the left thigh, extending from the inguinal fold as far down as the knee. It was noticed when the child was a few months old. It was made up of a number of small streaks which had a vertical direction, and these were united by smaller streaks to form an irregular meshwork. The individual streaks varied in width from 4 mm. to about 1 mm. They were brownish-red in tinge and here and there were covered with adherent scales and were hard to the touch. The streaks were broken up by more or less regular transverse fissures, giving them a moniliform appearance somewhat similar to Kaposi's Lichen ruber moniliformis. Several small isolated lesions suggested the papules of Lichen planus.

Dr. S. VERRÉ PEARSON (introduced by Dr. PENROSE) showed a *case for diagnosis*. The patient was a boy, aged 10, admitted into St. George's Hospital March 3rd, 1903, complaining of feeling tired, of weakness, and of pains in his feet.

History of present illness.—He has been weak and languid with a hacking cough for the last six weeks, but continued at school up till a fortnight ago, when he was obliged to leave off attending as his sister had measles.

On Thursday, February 26th, he complained of feeling cold; the next day he was lying about and complained of feeling tired, sleepy and thirsty, and since then of weakness, pains in the instep on walking, restless and wandering at night, and was feverish and thirsty. There has been no vomiting, no headache, no sore throat, no pains in the back, no running from the eyes or nose, and no sharp pains anywhere.

A rash appeared on the morning of March 2nd on the hands and arms, and for the last three nights he has been light-headed.

P.P.H.—He was an in-patient in Shadwell Children's Hospital three years ago under Dr. Coutts for disease of liver. In the way he lay about he was in a similar condition to that at the commencement of the present illness, but there was no rash. He attended as out-patient for about six months. About three months ago, after his discharge as an in-patient, there was a rash on the legs.

It is doubtful whether he had measles three and a-half to four years ago, but he had typhoid five years ago.

Family history.—Parents healthy. Nine brothers and sisters, all well except one with pertussis—one premature birth.

Present state.—March 6th.—The boy is lying quietly in bed, and says he is in no pain. He looks ill and is anæmic. There is a discrete eruption with the following characters : A certain amount of underlying blue mottling on the extremities. The eruption is papulo-macular. There is one large confluent patch the size of a florin in the centre of the right cheek. The greater number of the papules are about the size of a pin's head—nowhere vesicular, easily palpable. Many of them, but not all, arise in the close neighbourhood of hair-follicles.

There are small hemorrhagic points in the subcutaneous tissues, and these are specially well marked in the palms and soles, and on the plantar surfaces of the toes.

The eruption cannot be felt through the thick skin of the palms, soles and toes, elsewhere it is palpable.

The finger ends are shiny, tense, and very red ; gentle pressure removes the redness, which quickly returns on the removal of the pressure. There is no itching.

Cervical and axillary lymphatic glands are enlarged. There is a superficial stomatitis, and the patches along the cheeks opposite the alveolar borders have been compared to Koplik's spots, but they do not seem to be in agreement with the description, and they do not seem to present any differences from the ordinary superficial ulcerations found in stomatitis.

In the abdomen the spleen is felt to be much enlarged, the edge being three fingers' breadths below the margin of the thorax, and the spleen feels harder than natural.

Liver also harder than natural, edge thickened, and felt one finger's breadth below the right margin of the thorax. It is especially well felt in the right half of the epigastric region. Nothing else abnormal detected.

Circulatory system, &c.—Blood showed *leucopenia*. Hæmoglobin 83 per cent. ; red blood corpuscles, almost normal in number and appearance. There are extraordinarily few leucocytes present. The blood is sterile. Heart normal in size and position, and it is doubtful if other than a temporary hæmic murmur can be heard.

Respiratory system.—*Nasal.*—Non-offensive discharge from right

nostril on blowing through this nostril with the mouth shut and the left nostril kept shut.

Rhonchi all over both lungs; no other abnormal conditions detected.

Nervous system.—Normal. Eyes, fundi normal.

Genito-urinary system.—*Urine*.—Clear. High-coloured. Acid. Sp. gr. 10·24. No albumen.

A very slight swelling of the right wrist came on since March 6th.

The condition on exhibition was similar to that on March 6th, but the colour had faded somewhat and the infiltrated papules were the chief lesion present.

Dr. PENROSE showed a child, aged 1½ years, suffering from a *bullous eruption*. When the patient was a week old the mother noticed a white blister on the little finger of one hand, and soon afterwards blisters appeared upon the feet. Since that time blisters have appeared upon the arms and legs, but never on the neck or trunk. Three months ago one appeared upon the bridge of the nose. The blisters vary in size and contain generally clear, but sometimes blood-stained, serum, and they seem to be irritable when the patient gets warm. The bullæ may form upon apparently healthy skin, but generally there is an erythematous base upon which the bulla rises. On these erythematous areas there are occasionally seen small white spots, which consist of degenerate epithelial cells. There is nothing of interest in the history, and the child's condition is very good. Dr. Penrose said that the case appeared to be one of *Pemphigus circinatus*, and was similar to one which was under Dr. (now Sir Thomas) Barlow's care at Great Ormond Street fifteen or sixteen years ago, and which was the only case he could remember exactly like it.

Dr. J. J. PRINGLE brought forward a case of *multiple, non-pigmented Sarcomata* in a woman, aged 61, under the care of his colleague, Mr. Henry Morris. The patient, who appeared to be in fair general health, stated that the first growth appeared on the right side of the thorax at the level of the eighth rib certainly not more than three months previous to exhibition. A second growth developed soon afterwards in an accurately corresponding position on the left side,

but the rapidity of extension had been enormous, no less than 183 being now present. All of these were situated on the trunk and neck; they varied in size from a pea to an average fist, the largest being present over the lower part of the back. The smaller growths were all subcutaneous, but the skin was adherent to the larger ones. All were firm, of almost cartilaginous consistence, and perfectly painless when manipulated. They showed no trace of nerve distribution.

Two days previous to the meeting the patient developed ptosis of the left upper eyelid, accompanied by a good deal of pain in the orbital region, but without optic neuritis. Since the appearance of the tumours the patient had suffered from nearly persistent headache with occasional vomiting.

The exhibitor was of the opinion that the growths were probably secondary to internal sarcoma, although the most careful physical examination failed to discover any such condition. The presence of some dilated veins over the front of the chest suggested the possibility of mediastinal disease. A section of one of the growths was exhibited which showed the characteristics of a non-pigmented round-celled sarcoma.

Dr. SEQUEIRA showed (1) a case of *Alopecia areata neurotica* associated with Anorexia nervosa. The patient, a woman, aged 32, had been under the care of Dr. Percy Kidd since December, 1901. She had lost two brothers from phthisis, but her general health had been good until the birth of her first child in June, 1901. The delivery was difficult, and convalescence protracted. The child appeared to have given a great deal of trouble, and the patient's rest had been greatly interfered with. Four months after the confinement she began to be sick after every meal, and was finally reduced to taking only one pint of milk a day. When she came under Dr. Kidd's care she weighed six stones, eight pounds. There was no evidence of pulmonary trouble, and the only noticeable visceral change was an enlargement of the spleen. The blood showed nothing abnormal. The patient's mental condition was not impaired, but she complained of seeing visions of a dead relative, and heard "voices." At times she had visions of blood. She suffered a great deal from neuralgia, and had a number of stumps of decayed

teeth removed. Under careful feeding and rest she put on nearly three stones in weight. She relapsed in December, 1901, and still has frequent attacks of vomiting, and lives practically upon milk. In December, 1902, her hair began to come out very rapidly. There was no scaliness of the scalp. When she was shown the scalp was entirely bald over a large area. The area corresponds exactly to that supplied by the supraorbital and supratrochlear nerves on the right side, and to the supratrochlear nerve on the left—that is, there is a bald area from the forehead right back to the lambdoid suture on the right side, and a narrower area reaching as far as the corona on the left side. These areas are denuded of hair except at the extreme anterior margin, at the junction of the forehead and scalp. In this situation there are a few long perfectly normal hairs. The patient complains of pain over the affected area, and there are a few tender spots, but sensation to touch, heat and cold are unimpaired.

(2) A girl, aged 12 years, suffering from a *tuberculous eruption* on the legs. Eighteen months ago a follicular eruption appeared upon the middle of the outer surface of the right leg. Some of the follicles broke down and small, indolent, punched-out ulcers appeared. The area now involved is about four inches long by three inches wide. The part affected is slightly indurated and of a purple-brown colour. A small follicular lesion of a similar character appeared one month ago on the left leg in a similar position. The right knee-joint is chronically swollen, but it does not give the pulpy sensation upon palpation which is characteristic of tubercular synovitis. There is no pain in the joint. The lungs are free from disease, and there are no strumous glands. There is no history of tuberculosis in the family; nor any evidence of congenital syphilis.

Mr. ARTHUR SHILLITON showed an example of a *large papular secondary Syphilide*. Patient acquired the disease last June, and attended the Lock Hospital for three or four weeks when, all signs having cleared, he ceased attending, being, in his own opinion, cured. Six weeks ago he attended St. Bartholomew's Hospital with the eruption now seen, but only for two weeks, and one week ago he returned for treatment to the Lock Hospital. The eruption consists of large red papules grouped together, especially over the back and

extensor surfaces of the upper extremities; there are a few on the left chest, on the face, at the root of the nose, and over the eyebrows. Where the papules have run together the eruption is becoming of the tubercular type. His very fair white skin causes the eruption to be more than usually conspicuous.

Dr. STAINER showed a case of *Mycosis fungoides*. The patient, a healthy man, aged 43, was an in-patient at St. Thomas's Hospital, under the care of Mr. Clutton (who kindly allowed the case to be exhibited).

The disease was of nine months' duration, and was limited to the face, the back of the neck, the left axilla, and the upper part of the back.

The clinical characters of the individual lesions were:—

1. On the back of the neck, a large, flat, circular tumour, fully 5 inches in diameter, standing out about 1 inch from the surrounding healthy skin.

The surface was red, fleshy looking, smooth, oozing with purulent serum and showing here and there signs of threatening ulceration.

This tumour started nine months previously as a small, circumscribed, scaly patch, which was thought at first to be a patch of ring-worm.

2. In the left axillary space were two prominent infiltrated, flattened patches.

The larger was quite circular, about $1\frac{1}{2}$ inches in diameter, covered with scales and crusts, with a slight sticky discharge.

The smaller patch was not so circumscribed, and had a smooth erythematous surface.

3. On the left anterior axillary fold a circular area of 2 inches diameter showed as brownish-red points from some prominence of all the hair-follicles.

This area was not raised above the skin, but the prominent follicles produced a feeling of roughness to the touch.

4. On the face there were two lesions. One, on the left temple, was slightly raised above the surface, absolutely circular, with a diameter $1\frac{1}{2}$ inches, and a dry scaly surface.

The other lesion, on the malar prominence, was more irregular in shape, hardly raised above the surface, and discharged slightly.

5. On the back were two elongated infiltrated patches with scaly surfaces.

The direction of the long axes of these lesions suggested strongly that either they were on the sites of previous scratch marks, or that they actually were the result of inoculation by scratching.

The patient during the last nine months had in no way suffered in health.

Dr. PARKES WEBER showed a *case for diagnosis*. The patient was a rather stout man, aged 46 years, a German boot-finisher in London, attending the out-patient department under Dr. Lehmann at the German Hospital. On the right side of the scrotum there is an indurated thickened patch of skin and subcutaneous tissue, the surface of which is red, shiny, and slightly abraded, and is moist with a little thin discharge. The affected area is about as large as a five-shilling piece. The patient likewise has varicose veins and chronic eczema, and ulceration of both legs. The scrotal disease is said to have commenced two years ago as "eczema," about the same time as he first began to suffer from eczema of the legs.

Various methods of treatment have been tried, but with little, if any, benefit, although there seems to have been temporary improvement. The patient's general health has usually been good. He had gonorrhœa twenty-five years ago, but he thinks that he has not had syphilis. An affection of the scrotum analogous to Paget's disease of the breast was thought of as a possible diagnosis.

Dr. WHITFIELD showed (1) A little girl, aged 6, suffering from a *peculiar symmetrical eruption* on the face, arms, legs and buttocks. History was almost absent, as the doctor in the country under whose care the child was had not yet communicated with Dr. Still, who had had the child brought up to the hospital. It was, however, known that the disease had existed about three years, and changed character from time to time. On admittance the condition was exactly the same as when exhibited. On the face, occupying the greater part of both cheeks, were large purple-red patches almost the size of the palm of the hand. The edges of these were slightly gyrate and quite circumscribed. The patches were hardly raised above the surface, but on palpation they gave a resistance which

suggested infiltration, and on the right cheek there were two nodules in the centre of the patch which appeared to consist of fibrous overgrowth and dilated vessels; a certain amount of atrophy also appeared to have occurred, as shown by the wrinkling of the surface. The rest of the patches consisted of multiple dilated vessels which could be emptied on pressure, leaving a yellowish stain resembling that on pressing out the blood from the fixed type of Lupus erythematosus. A similar patch about the size of a florin occupied the centre of the chin. The lobes of the ears and the contiguous portions of the conchæ were the seat of swollen, purple-red infiltrations, with hard ivory-like margins, very abrupt and gyrate in outline. On the elbows there were large, florin-sized, circular patches of raised yellowish-purple skin with a defined edge and a slight tendency to resolution in the centre, resembling to some extent the lesions of a non-vesicular Erythema iris. Round these main patches and on the wrists there were similar smaller patches varying in diameter from a quarter to half an inch. These patches were of soft, cushiony consistence, left a brightish yellow colour on squeezing out the blood, and showed no alteration in the over-lying epidermis. On the buttocks were two symmetrical patches of the size of the palm of the hand, resembling to a great extent those on the cheeks, but being more discretely nodular. On the legs below the knee there were some brownish stains suggesting that patches had existed there and had faded away. The child was well nourished and in excellent health generally, and the eruption seemed to cause no inconvenience.

Dr. Whitfield said that he owed the case to Dr. Still, who had kindly had her sent up from the country into the wards so that she might be exhibited to the members of the Society. He was bound to confess that he knew of no disease quite resembling this, and he brought it up to see if any of the members could recognise the affection.

Dr. RADCLIFFE-CROCKER said that the disease was outside anything in his experience and that he believed it to be unique.

Dr. JAMES GALLOWAY remarked that Dr. Whitfield's case was a very striking one and quite anomalous, stating that to his knowledge no exactly similar case had been presented to the Society. He had examined the patient carefully, and would venture the suggestion that the disease, presenting as it did ringed and nodular areas of growth on the extremities, might possibly be an example of the same class described by Dr. Colcott Fox, Dr. Dubreuilh, Dr.

Crocker and himself, under the names of *Lichen annularis*, ringed eruption, and *Granuloma annulare*.

He would draw attention to a paper by Messrs. C. Rasch and F. Gregersen, of Copenhagen, appearing in the *Archiv für Dermatologie*, Bd. LXIV., Heft 3, 1903, under the title "On a new Type of the Sarcoid Growths of the Skin."

In their paper these authors described a case of "ringed eruption" affecting the hands of a lady 83 years of age. The description given by the authors leaves little doubt that the case was of the same nature as those described in this country and by Dr. Dubreuilh under the names mentioned. The microscopic appearances, of which figures are given, bear out their diagnosis, and indeed the authors themselves identify the Danish case with those already described.

In discussing the histology of the case Messrs. Rasch and Gregersen are inclined to consider that the whole group of cases should be classified in the same category as the "multiple benign sarcoid of the skin" described by Dr. C. Boeck (*Journ. Cut. Gen.-Urin. Dis.*, December, 1899).

The extensive distribution of the disease in Dr. Whitfield's case, its occurrence in large areas, and the intensity of the erythema, especially on the cheeks, are the anomalous features. The smaller lesions, however, approximate in many particulars to the *Lichen annularis* type, and Dr. Galloway suggested that the case should be studied in view of the observations made by the various authors alluded to.

(2) A woman, aged 42, suffering from a nodular eruption on the nose and cheeks. The patient was sent up two years ago by Dr. Bontor to King's College Hospital, and the diagnosis then made was *hypertrophic Syphilide* of the nose. The eruption was at this time almost limited to the nose, though there was a group of ringed papules on the left cheek. (A photograph of the condition at this time was shown.) Under mercurial treatment by the mouth the disease almost entirely disappeared, and the patient was so satisfied that she stopped treatment. It was perhaps noteworthy that at this time no improvement could be obtained by iodide of potassium. Some few months later the patient became pregnant, and during the pregnancy the nose became again affected, and this time the eruption spread on to the cheeks and very closely resembled *lupus vulgaris*.

On exhibition the nose was much swollen and covered with large papules of the size of a split pea of brownish-red colour and very hard consistency. At the alæ of the nose slight ulceration had taken place, but this was quite superficial, and no involvement of the cartilage or the bone of the nose could be made out. It appeared, too, that the inside of the nose was healthy. On the cheeks there were sheets of these large nodules, and here and there some worm-eaten ulceration had taken place, but the destruction was very

slight, and there was no tendency to central involution such as one usually sees in syphilis. The areas on the cheeks affected were elliptical with the long axis parallel to the naso-labial fold; in fact, exactly the distribution which is so often seen in *Lupus vulgaris*. There was a large soft gland behind the left angle of the jawbone and another under the chin. Dr. Whitfield said that he thought that the lesions were clinically almost indistinguishable from lupus, but he would draw attention to the facts that the hardness was greater than that usually found in lupus, the destruction, where present, was of a peculiar worm-eaten character, and that the inside of the nose was healthy. He thought that these almost justified the diagnosis of syphilis, though there was no shadow of history of the disease present. This had been his original diagnosis two years ago in spite of the eruption's having resisted treatment with iodide. He thought the results of the mercurial treatment bore out the diagnosis, but he had brought the case up because he thought it one of such great difficulty.

Drs. COLCOTT FOX and SEQUEIRA, who had examined the case before hearing the history, were inclined to think that the case was one of *Lupus vulgaris*, but after hearing the history they admitted that they thought it was probably syphilis. This seemed to be the most generally accepted opinion of the members present.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, February 25th, 1903, Dr. STOWERS in the Chair.

The following cases were exhibited :—

Dr. ABRAHAM showed (1) a woman, aged 39, the subject of *Tinea tonsurans*. She brought her little boy to the hospital a month ago with the same condition, associated with *Tinea circinata*. A few of the stumps of hairs were extracted from the woman's head, and yielded abundant spores, which seemed to be a variety of endothrix [specimens exhibited]. At the same time there were groups of small spores outside the hairs. He was not yet certain whether it was a case of megalosporon or microsporon. It was only the fourth case in an adult which he had seen since he had been interested in skin-

diseases. The view that *Tinea tonsurans* never appeared on the adult scalp was not quite correct. Three or four years ago he showed, at this Society, a man between 30 and 40 years of age with typical trichophyton of the scalp. Another case was that of a student, aged 23, who had been under his care, and the fourth a middle-aged woman, whose children had ringworm. The last-mentioned was very obstinate to treatment.

(2) A middle-aged man with a *peculiar varioliform eruption*. The patient had lived many years in South Africa, and was an engineer. The lesions commenced as papules, which soon became vesicular, and some presented an umbilicated appearance. Most of them left an atrophic scar when disappearing. They might be called vesiculo-varioliform lesions. He did not know its exact nature, but had it appeared on the face he would have called it "*Acne varioliformis*." The patient had no subjective sensations. The lesions came out in crops all over his body, arms and legs, but not on his face. He had never had syphilis. He (Dr. Abraham) had been informed by a medical man that he had seen similar cases in South Africa, and that it was spoken of among the natives there as a sort of small-pox. He proposed to show sections of the skin at the next meeting.

(3) A baby, aged 18 months, the subject of *Ichthyosis*. It was brought to Blackfriars Hospital last week. The condition appeared to have started at birth, or very shortly afterwards, as the mother did not notice any eruption of the skin for a fortnight, except that the baby's face appeared dirty. When seen last week, there were large plaques of skin scaling off all over the body and limbs, with furrows between. It had almost the appearance of an exfoliative dermatitis. The places where some of the large scales had been were now evident. Both flexor and extensor surfaces were involved. The mother stated that the child did not perspire much, but sometimes blisters came up on the head. He had not seen an exactly similar case before. The mother herself had a slightly rough skin. This was her only child.

The CHAIRMAN and Dr. BOWLES recommended thorough treatment by means of oil, both internally and externally.

(4) A *case for diagnosis*. Two years ago the patient, a girl, had enteric fever, and immediately afterwards bluish-red spots came out on her face, arms, hands and legs. If they were not spots of Lupus

erythematosus he did not know what to regard them as. The lesions did not vanish. The patient was not a sufferer from chilblains. Some telangiectatic condition was noticed on the right ear. The lesions were never pustular. She had been attending hospital a month, and the lesions were certainly paler than at first.

Dr. ALFRED EDDOWES showed a case of *infection from sebaceous cysts* in a man who came to him three weeks ago with an acute diffused eruption practically covering, and sharply limited to, the areas clothed by his vest and pants. It was at once claimed as a "vest rash" by some of the medical men who had seen it. The skin now was merely reddened, and was recovering. When first seen there was some exudation and crusting, and the appearance presented was much like the superficial folliculitis and diffused dermatitis produced by a mild application of croton oil. As Dr. Eddowes did not believe such a rash could possibly be produced by the irritation of a vest *per se*, he looked for a source of infection, and found it (as he believed without doubt) in a sebaceous cyst which was inflamed and slack. He had not ventured to squeeze it hard enough to see if any solid material could be squeezed out of it. He had opened the cyst, and found the contents somewhat dry, extremely offensive and, as the members would see under the microscope, it was a mass of cholestrin crystals and cell-debris crowded with micrococci. He believed that these sebaceous cysts were almost always, if not invariably, the result of infection of sebaceous glands combined with a more or less complete stricture of the duct. In this condition they might at any time, owing to distension or external pressure, overflow and infect the skin surface, especially when circumstances were favourable, such as when warm days found us working in winter clothing. He had on several occasions reported cases of infection from such cysts which he looked upon as little cess-pools, and he strongly recommended dermatologists to look to them as a great source of danger, and not to ignore them or write of them as if they were of no importance. Some writers seem to think that they need not be interfered with unless they are large and disfiguring, in which case they seemed to think they should be handed over to the surgeon. The important fact to be remembered is that the large tight ones did little or no harm. Dermatologists should take in hand and always treat those which were liable to

become tense and slack by turns owing to the duct not being obliterated, and therefore allowing a gradual or intermittent oozing of septic fluid or fat teeming with micro-organisms. There was no fine line to be drawn between a large cyst and those small, deeply-seated acne cysts so commonly and erroneously termed indurated acne.

Dr. GRAHAM LITTLE showed (1) a case of *Urticaria papulosa* in an infant aged 2 years. The eruption had appeared acutely a fortnight previously. It consisted of very closely aggregated pink papules indistinguishable from those of Lichen planus, covering the legs thickly, the arms less thickly, and being also very numerous on the back and the abdomen. Itching was intense, but there were no wheals. The case was probably of the same type as those recorded some years ago by Colcott Fox as cases of Lichen infantum, a designation which that observer had seen reason to alter, and these cases were now usually classed as urticarial. The interest in this particular case lay in the acute and extensive invasion, and the rather older age at which it had appeared. The glands were enlarged in the groin and axilla, a circumstance which might be thought to favour the diagnosis of prurigo, but it was unusual to find prurigo commencing at this age without antecedent urticarial lesions.

As to the claim that this case was an Urticaria, Dr. EDDOWES said it was essentially a papular eruption of uniform type, firm, discrete and clearly permanent, and due to cell-infiltration, *i.e.*, a lichen. It was in no sense an urticaria or an inflammatory oedema.

(2) A case of *perforating Ulcer* in a man aged 50, who was ill-nourished but not otherwise ill. The ulcer was in the ball of the great toe of the right foot, and had persisted for the past fifteen months. It was about three-quarters of an inch deep and the edges were white and indolent. There was no discharge or inflammation about it, and no pain until quite recently. The man had been examined by Dr. Luff, who had found no symptoms of tabes. There was no history of syphilis or reason to suspect its existence. The urine contained neither albumen or sugar. Trophic ulcers preceding other symptoms of ataxia by several years had been recorded and it was probable this was such a case.

(3) A case of *Eczema seborrhoicum areatum* in a man aged 80.

Patches of seborrhœa had been present on the hands for at least three years, and fresh patches had appeared on the thighs and legs. These were always dry and circinate and singularly resistant to treatment; there was seborrhœa capitis with consequent thinning of the hair on the vertex.

(4) A case of a *recurrent bullous eruption*, with subsequent exfoliative dermatitis, which was shown as a probable case of *Pemphigus foliaceus*. The subject, a young woman, aged 20, had been an in-patient of St. Mary's Hospital for three months last year. A fuller report of this case will be submitted later.

Dr. ALFRED EDDOWES was not disposed to complain of the term "pemphigus" being applied to Dr. Little's fourth case, because that term still included a number of bullous eruptions, the nature of which was only now to some extent cleared up. He was rather inclined to take the view that this eruption was probably due to a streptococcus infection. A case had lately been described in the *Monats. f. prakt. Dermat.* by Dr. Krzyztałowicz which seemed in many points similar to the one before us, for which the very descriptive and comprehensive title of "Dermatitis bullosa streptogenes chronica" had been suggested.

Dr. T. D. SAVILL showed a coloured boy, aged 13, who had what he regarded as *Tinea imbricata*. He would like to hear a definition of the disease so-called. Up to his eleventh year the patient had lived in Ceylon. There were circinate patches of scurfy and thickened skin on both sides of the neck, none elsewhere. The patches had appeared when he was 8, and had persisted without change ever since, though a great variety of very active treatment had been tried by Dr. Savill for the past two years. Microscopic sections of the skin were exhibited under the microscope, showing that the cuticle was permeated by a fungus, consisting of spores and mycelium. Possibly it was a trichophytosis. He would procure and examine some fresh scrapings for cultivation; so far cultures had not been obtained from the case. He would like to hear the opinion of members upon this case as to whether it coincided with the *Tinea imbricata* of Manson; or whether it was a most intractable case of *Tinea circinata*.

Mr. PERNET did not consider the case was one of *Tinea imbricata*. In his opinion it was a *Tinea circinata* of the tropics (*Tinea tropica*), which was often very rebellious to treatment. He took this opportunity of showing a photograph of a case of *Tinea imbricata* for which he was indebted to Mr. Gimlette, Residency Surgeon at Kuala Lipis, Pahang, Malay Peninsula, who had also sent him scales.

In these he had found foetid masses of interlacing mycelia, some plain, others (most of them) segmented, the segments being short and thick, and in many cases rounded in shape. The scheme of the branching was dichotomous. The mycelial elements varied in width. Irregularly scattered about were numerous "spores" in rows and clumps. Mr. Pernet was trying to cultivate the fungus, but had not yet decided if the growths he had obtained were definitely those of the fungus causing *Tinea imbricata*.

Mr. SHILLITOE also showed photographs of *Tinea imbricata*.

Mr. A. SHILLITOE showed (1) a case of *Syphilomata of the tongue and lip*. This patient acquired Syphilis last April, but had no treatment until the 31st, when he attended the Lock Hospital with severe rupia and a sloughing sore, which had destroyed almost the whole of the sheath of the penis. A week ago he developed the condition seen on the tongue and upper lip. A dry, hard, slightly excavated, non-discharging sore, somewhat resembling a rupial patch from which the crust had been too early removed.

(2) *A gyrate Syphilide* in a man aged 49, who acquired the disease last October. The eruption is confined to the back of the neck, consisting of quadrilateral figures each about three-quarters of an inch across.

Mr. GEORGE PERNET then read the following short paper on *Herpes zoster*:—In 1897, I read a paper* before this Society in which I related a case of what I considered to be recurrent right-sided Herpes zoster. I suggested that the eruption was perhaps due to an uncorrected error of refraction: astigmatism of right eye, slight hypermetropia of left. Since November, 1896, when the last attack occurred, the patient had worn glasses for near work, and up to the present (February, 1903) there has been no recurrence of the eruption. Of course, I am quite aware that it is difficult to avoid the *post hoc propter hoc* fallacy in this as in other cases, as one is perhaps prone to ascribe to remedies what may be after all merely a natural evolution, especially in the case of prophylactic measures. That some forms of migraine and of headache are benefited by correcting errors of refraction appears to be a fact, although Möbius† looks upon the ocular condition as coincident only. In connection with

* *Brit. Journ. of Dermat.*, Vol. IX., 1897, p. 151. "Trans. Derm. Soc. G. B. and I.," 1896-97, Vol. III., p. 101.

† "Die Migräne," Nothnagel's Spec. Path. u. Therap., Bd. XII., III. Theil; p. 50 (of separate monograph), 1894.

hemicrania, I have seen zoster associated with it, and I may instance the cases of mother and son, who both had migraine and errors of refraction, and who both had an intercostal attack of Herpes zoster before glasses were worn. Whether the association of migraine and zoster has been pointed out before I do not know. At any rate Möbius in his monograph on migraine apparently makes no mention of zoster. Whether the association is accidental or otherwise I am not prepared to say positively. I am inclined to think there is some relation between the two.

When Jacquet put forward his theory as to the dental origin of Alopecia areata, it struck me at once that errors of refraction might in a similar way be factors, that is assuming that Jacquet's view is correct, and may account for bald patches in some cases. That Alopecia areata may be either parasitic or of nerve origin is, I think, undoubted, although, as far as I have seen, the former appears to be the more common of the two. As to the dental theory, it need scarcely be pointed out that bad teeth are common. On the other hand, Alopecia areata may occur in patients with very good teeth; or toothache may occur subsequently to the denudation of the scalp. As to the rôle of errors of refraction in Alopecia areata, the same difficulty arises as in the cases of Herpes zoster. I propose to deal with the connection of Alopecia areata and ocular conditions on a future occasion. Migraine and Alopecia areata are sometimes associated, but in the worst case of Migraine I have ever seen or read about, the patient—a lady I have had under observation—has not had any loss of hair in patches. I may add that in her case the correction of the hypermetropia (slight in degree) has made no difference whatever to the attacks of hemicrania.

REVIEW.

HANDBOOK OF THE PATHOLOGY OF THE SKIN.*

Few publications which have appeared during recent years, certainly none

* *Handbook of the Pathology of the Skin.* An Introduction to the Histology, Pathology and Bacteriology of the Skin, with special reference to technique. J. M. H. MacLeod, M.A., M.D., M.R.C.P. (London: H. K. Lewis. 1903. Pp. xxiv. and 408. Demy 8vo, with eight coloured and thirty-two black and white Plates. Price 15s. net.)

connected with the subject of Dermatology, may be more aptly said "to supply a long-felt want" than the work before us.

Up to the present time it has been almost impossible for any but the privileged few to follow and appreciate the many advances which have been made of late years in our knowledge of the Histopathology of the Skin, and in the methods by which such knowledge has been obtained.

For those who have made a special study of the subject, and who are in touch with the dermatological literature of various countries, material in abundance in the form of journal articles and text-books has appeared; but for those who are commencing the subject, or who wish to follow what is being done without making the subject a life study, the material has hitherto been but scanty, and has frequently presented such an array of novel terminology and apparently intricate methods, as to frighten them away rather than attract them towards its further study.

With the appearance of Dr. MacLeod's work this is all ended. Here the would-be student will find an account of all the best that has been done, and the best way of doing it, presented to him in a simple, clear, concise and attractive form.

We hope and believe that many will be stimulated thereby to take an active interest in a branch of Pathology which should prove particularly fertile in results, seeing that the skin is the only organ of the body in which clinical appearances and structural changes may be studied simultaneously.

In making the above remarks we do not wish, for one moment, to appear in any sense to minimise the value of the treatises which have gone before, or to depreciate the splendid work which has been done by others in this branch of Dermatology.

On the contrary, we realise that were it not for that work, this book could not have appeared in its present form. Indeed, it is largely the gathering together of such work, the sifting of the good from the bad, and the presentation of the former in such a form as to make it accessible to all, which gives to this Handbook its great value and importance. When there is added to this the author's wide personal experience in the subject with which he deals, both as a research worker and as a teacher, one realises that the result is no ordinary production.

We may consider the work in three parts. The first, which occupies some half-dozen chapters, deals with the laboratory requisites, general technique and methods, and calls for no special comment. It is, throughout, brief and to the point, and contains just what the worker wants to know. The second part forms the bulk of the work, and it is here that the author displays his admirable sense of what a student requires, and how it may be best provided for him. The arrangement or plan of this section is very simple. Each item of the many which make up the complex skin organ is dealt with separately. Its development and its normal structure are described, with useful notes on any particular features it may present. The technique, specially required for its demonstration, is fully given. A systematic account of the various pathological changes which are particularly associated with the part in question follows, illustrated by examples of "type-diseases." The various theories which have been or are at present held as to the significance of these changes are discussed, and finally, at the end of each of these chapters, or groups of chapters, a useful table of pathological changes and of the diseases in which they occur is drawn up.

Such is the plan of the work before us, and although, like all other plans, it has its drawbacks, yet it presents so many advantages to the student that we consider it has been wisely chosen. The third and last part deals with the Bacteriology of the Skin, together with the various parasitic affections, and here we realise that the author has been compelled in a student's handbook to compress his subject considerably. This, however, has been done judiciously, and quite enough has been retained for the purposes for which it is required.

In reviewing the work as a whole, we are chiefly impressed by its thoroughness and "finish," by the fair and impartial manner in which the views of the various Schools are given and discussed, and by the general high level of excellence throughout. We feel that everything in the book has been carefully weighed and proved of value before being admitted, and consequently that it is all absolutely reliable.

By no means the least valuable part of the work are the splendid plates with which it is so liberally supplied. Here the author shows that he is not only a teacher and a master of technique, but also an artist. Anything more instructive, and at the same time more artistic, than these illustrations we have never seen in medical literature.

We heartily congratulate Dr. MacLeod on the valuable addition which he has made, not only to the literature of dermatology, but, also, to that of pathology in general. He has produced a work which, so far as we know, is unique, and which must for many years to come be *the* handbook for all students of dermatology.

Much praise is due to the publishers for the excellent style in which the work is produced; and as for the illustrations, higher praise cannot be given, than to say, that they are reproduced in a manner worthy of the author's skilful delineation.

ARTHUR HALL.

CURRENT LITERATURE.

EPIDERMOLYSIS BULLOSA HEREDITARIA. G. W. WENDE. (*Journ. of Cut. and Gen.-Urin. Dis.*, December, 1902.)

WITH the diagnosis *Epidermolysis bullosa hereditaria* or *congenital bullous Dermatitis*, Prof. G. W. Wendé, of Buffalo, describes a case with very unusual features. The parents were cousins, but no history of hereditary disposition to the disease, and no features of moment, were elicited in the family history of former generations. The second child died at two months; the third died at two years, but for the last year of life exhibited an eruption which appeared about the mouth and anus, and finally spread to other parts; the fourth child was healthy. The patient reported upon was apparently the eldest child, and an eruption, at first red, then moist, and finally scaly, developed about the mouth and anus at three weeks old, and so continued with variations in extent and form until three years of age. Then blisters appeared and recurred about the fingers, palms and backs of hands, and similarly on the soles and heels, and later on the knees. There seems to have been a considerable remission during the hotter months. Vesicles also evolved on the tongue and buccal mucous membrane.

When under observation at seven years old the boy was fairly well developed and in satisfactory general health. The scalp had lost its hair, except for a few lanugo-hairs and a small pigmented hairy nœvus. The fall of the scalp hair commenced with the onset of the eruption, but no evidence of bleb-formation or inflammation was ever discovered on the scalp. The nails of the fingers and toes were gradually lost, and the author is disposed to regard this dystrophy as due to influences similar to that causing the baldness rather than to eruptions. The eyebrows were indicated by scanty lanugo-hairs, and the eyelashes were scanty. The mouth was surrounded by a "raw," shiny, elliptical area, covered with fine scales, with an inflammatory border. An elevated red border also encircled the nares, and extended over the bridge of the nose and part of the right cheek, and thus enclosed a scaly half square. There was a ciliary blepharitis, and a scaly inflamed area extending from the eyelids. The mouth contained many erosions, and two vesicles were present on the buccal mucous membrane. The tongue was smooth, bright red and raw-looking in the centre, with milk-white spots upon the edges.

In the perianal region the condition was similar to that round the mouth, but more pronounced, and the borders blistered. The skin about the urinary meatus and over the anterior third of the penis was likewise scaly with an erythematous border. On the backs of the hands, fingers, and up to an abrupt symmetrical line just above the wrists, the skin was much damaged and covered with large scales. The epidermis was elevated by underlying fluid (? the border), and vesicles were found over the affected area. The palms were covered with *discrete* bullæ. Over each knee was a large, irregular, infiltrated, elliptical, scaling patch with a bullous margin; and over the exterior surface of the ankle-joints was another desquamating area. The interdigital surfaces and soles, except the arch, were likewise implicated. Special recrudescences were attributed to mental excitement, and it is curious that experimental mechanical irritation failed to excite the formation of blebs, although subcutaneous injections of a fluid did so.

Thin-walled bullæ, with serous or blood contents, were found on various parts of the body, mostly at the extremities; but the author does not make it clear whether other localities than those detailed above were involved. Wende also states that microscopical examination showed the vesicles to be situated between the rete and the papillary layer; but in the illustration given there are deeper-seated irregular rents in the dermis which seem to be indicated as vesicles.

This remarkable case is specially compared with one described by Hoffmann (*Münchener Med. Wochenschrift*, 1895, p. 45).

T. C. F.

FOUR FORMS OF GENERALIZED EXFOLIATIVE DERMATITIS. J. T. BOWEN. (*Journ. of Cut. and Gen.-Urin. Dis.*, December, 1902.)

J. T. BOWEN describes four cases illustrating four forms of *generalized exfoliative Dermatitis* (*Erythrodermies exfoliantes généralisées*, Besnier), presumably due, he thinks, to different etiological agencies.

CASE I. was an example of recurrent desquamative scarlatiniform Erythema or Dermatitis in a young woman. Bowen thinks Besnier's position reasonable, viz., that in certain predisposed persons many different causes, as medicaments, toxins

local irritants, &c., may determine this manifestation, and that the cause in the various attacks may not always be the same.

CASE II. illustrates the *Dermatitis exfoliativa* of E. Wilson, the *Dermatite exfoliative généralisée* of Brocq. A clergyman, 72 years old, with usually good health, except for an attack of rheumatism and iritis, apparently leaving a slight systolic murmur, was attacked on the face and head with violent erythema and considerable œdema, which rapidly spread to the rest of the body and became absolutely universal. Scaling was profuse. The general health remained excellent, and the inflammation slowly subsided over a year or more. The eruption cleared up by the formation of "white spots" with a convex margin, simulating leucoderma.

CASE III. was an example of *Erythrodermie exfoliante secondaire, accidentelle*, of Besnier. The eruption, in a single woman of 40, who had suffered from two previous attacks of intense dermatitis of the face and hands, began with the appearances of an artificial dermatitis (e.g., rhus poisoning), and developed into a generalized exfoliative dermatitis. There was no change for a year, and then a gradual improvement with frequent relapses. This class of case may be consecutive to psoriasis, eczema, Lichen planus, &c., or be caused by ingestion of a drug, or by an external irritant. Crocker says they may be grave.

CASE IV. was an example of the rare, pure *Pityriasis rubra of the Hebra type*. The eruption began in a woman of 25 years, in good health, on the face, like an erythematous and scaly eczema, and in spite of treatment, steadily progressed by the formation of new patches, which coalesced, and so became universal. The condition deepened over the next four years, and there were thick keratoses of the palms and soles, and fine branny desquamation. The hair fell after three years, and the nails were profoundly altered. The patient died from exhaustion after five years, and in the last year there was marked atrophy of the entire integument with loss of almost all the subcutaneous fat.

Bowen thinks that the theory that we have in Pityriasis rubra, a condition which readily lends itself to inoculation with tuberculosis, is far more probable than the assumption that the cutaneous changes are caused by the action of the bacillus, whether directly or indirectly.

T. C. F.

ZOSTER OF THE ELEVENTH DORSAL ROOT FOLLOWED BY A GENERAL HERPETIC ERUPTION, PART OF WHICH WAS ALSO SEGMENTED IN DISTRIBUTION. C. J. ALDRICH. (*Journ. of Cut. and Gen.-Urin. Dis.*, December, 1902.)

CHARLES J. ALDRICH, of Cleveland, relates that a man, aged 33, was attacked with a sensation of general malaise, chills, fever, and general aching pains, and a day or two later experienced severe pain, and twenty-four hours after, a zoster in the area of the cutaneous distribution of the eleventh dorsal segment. Some days later again he developed a typical herpetic eruption of very extensive distribution (diagrams are given) on the skin and on the conjunctival, buccal and labial surfaces.

T. C. F.

A SEVERE LATE-APPEARING, BULLOUS MERCURIAL ERUPTION AFTER TWELVE INUNCTIONS WITH BLUE OINTMENT.

P. THIMM. (*Dermatologische Zeitschrift*, Bd. IX., Heft 6, December, 1902, p. 782.)

THE history of the extremely interesting case which is the subject of this report is as follows:—On November 29th, 1901, a young woman, aged 24, sought advice on account of an early syphilis, the beginning of which, according to both the state of the disease and the history, dated from four or five months previously. The rash had faded to a number of pigmented spots and a few papules on the palms, the chief symptoms being general debility, headache, and pain in the joints, mouth, and genitals. There were generalised adenitis, and numerous moist papules in the mouth and throat with condylomata on the vulva and anus. The woman was in the ninth month of her first pregnancy.

Treatment was begun at once, and consisted of painting the mouth with sublimate in ether and alcohol, powdering the condylomata with calomel and rubbing in three grams of mercury resorbin per diem, at the hands of a masseuse. The inunctions were continued until December 12th, when they had to be interrupted on account of the appearance of a mercurial stomatitis and a very irritable circumscribed mercurial erythema, distributed chiefly upon the flexor surfaces of the extremities, the axillæ, and hypogastrium. All signs of syphilis had disappeared with the exception of a slight enlargement of the lymph nodes. In a few days, under a zinc paste, the erythema disappeared, leaving only the slightest redness of the backs of the knees and elbows and axillæ. No further mercury was given, as the confinement was daily expected. The patient then entered the *privatklinik* of Professor Menge, and on December 28th was delivered naturally of an apparently healthy boy. Two days later she complained of a severe itching all over the body, and a nearly universal, diffuse, erythematous redness of the skin appeared. The greater part of the body, and especially the face, showed a definite but not very great œdema. Under the zinc paste the condition again improved, but on January 1st, 1902, the itching grew much more severe, and the face and the hypogastrium began to discharge. The temperature rose to 38·9°. On account of the weakness of the pulse the patient was given some digitalis. Two days later (January 3rd) the skin was markedly œdematous, the face especially, the eyes, ears, and lips were extraordinarily swollen, and the skin had run on into an exuding eczematous surface, partly vesicular but crusted on the scalp. The first impression given was that of Pemphigus foliaceus. There were present, especially on the palms and soles, but also on the thighs, forearms, and hypogastrium, numerous, large, flaccid bullæ with sero-pustular contents. There was a general discharging surface and a marked tendency to lamellar scaling. By this time the pulse was extremely poor and the temperature had risen to 39·2°. She was ordered in addition to the digitalis internally, a complete wrapping in solution of aluminium acetate. Next day her condition was better, but twenty-four hours later a new eruption of the same kind had appeared. There was never any sign of stomatitis at this time, and the bowels were rather confined. On the other hand the lochia were profuse and very foetid, and the vaginal orifice was much swollen and covered with purulent secretion. The patient was then treated in the continuous bath, in which she did well, the surface drying up and the whole of the superficial epidermis coming away in great flakes. After the disappearance of the eruption

the whole of the scalp hair fell out with the exception of a few tufts. On March 25th the patient brought up her child in a bad state, and it was ordered $\frac{1}{2}$ gram of blue ointment to be rubbed in daily by the father. The patient disobeyed, however, and rubbed it in herself, and two days later appeared with an eruption exactly similar to that which had come out after her own inunctions. This attack, however, went away in a few days, and on April 14th she came with a relapse of the syphilis. After due consideration it was decided to try treatment by injection, beginning with $\frac{1}{4}$ c.c. of 0.5 per cent. sublimate solution, and rising gradually to 2 c.c. After the first injection some redness and itching appeared, but this died away under treatment, and the rest of the injections were given without further trouble.

The interest of this case lies, of course, in the extraordinarily late appearance (eighteen days) after the cessation of the drug. Thimm admits that such cases are not unknown, but points out that these late ones are usually due to the use of insoluble mercurial salts in the form of injections, and in such a case one may, of course, be dealing with delayed absorption. Thimm explains the eruption by the fact of the pregnancy's occurrence in a weakly individual soon after the exhibition of the drug.

[On reading the above excellent report it occurred to me that mercurial salts might possibly have been used for the purposes of purification at the confinement. I therefore wrote to Dr. Thimm and made inquiry as to this, and he most politely investigated the matter and found that no mercurials, indeed, no antiseptics of any kind, had been used at the labour. The case is, therefore, above suspicion as an example of delayed eruption after the use of inunction.] A. W.

CONDITION OF THE PAPILLARY HAIRS IN WHICH THEY WERE EASILY PULLED OUT TOGETHER WITH THEIR ROOT-SHEATHS. S. GIOVANNI. (*Dermatologische Zeitschrift*, Bd. IX., Heft 6, p. 809.)

THE patients who exhibited this curious condition were two brothers and a sister, aged respectively 31, 23, and 33. Certain accidents occurred in the history of the two brothers, but nothing to lead one to suppose any relation with the scalp condition.

In the two brothers the condition was still present, and had existed eleven years; whereas in the sister the condition had persisted for nine years, but had gradually disappeared in the last two years. On pulling the hair with the finger and thumb the lightest traction succeeded in extracting a bunch of hairs, some with their root-sheaths, others without, but all with entire papillary bulbs.

Microscopic examination gave purely negative results, and the condition, even in the brothers, appeared to be passing away as, although the hairs were still very easily extracted, the root-sheath did not accompany them as invariably as it had done some time ago. A. W.

TWO CASES OF TINEA FAVOSA CAPITIS—RECOVERY UNDER TREATMENT WITH IZAL. Sir DYCE DUCKWORTH, M.D., LL.D. (*St. Bartholomew's Hospital Reports*, Vol. XXXVIII., 1902, p. 155.)

CASE I.—An ill-nourished boy, aged 7 years. The disease was of long standing; on admission a large area of the head presented the appearance of the rind of old

Stilton cheese, being covered with a crust of porous friable matter about three-quarters of an inch thick. No typical yellow cups; mousy odour not marked. After removal of the crust with oil and poultices, numerous areas of baldness were found, with reddened patches where the hair still existed. The favus fungus was found in abundance.

Treatment.—Epilation, various parasiticide ointments, including oil of cade; tonics, codliver oil, liberal diet. After six months no gain in body-weight; the favus still existed. After a further lapse of time (apparently four months or so) the boy began to gain in weight. A solution of izal in glycerine and water was next applied constantly to the scalp, and the strength increased till nearly pure izal was tolerated. Marked improvement then began; the spores became less abundant, the hair commenced to grow. After fifteen months in hospital the boy went to the convalescent home, cured; and the cure appears permanent. The hair has grown well in all but the original bald spots.

CASE II.—A sister of No. 1.—A healthy girl, aged 18, who had apparently caught the disease from a third member of the family, viz., a sister with whom she slept. The disease was of long standing; there were scattered bald patches all over the scalp; in places several sulphur-coloured cups; a mousy odour. Occiput covered with thick seborrhœal crusts. Parasite readily detected. Treatment: tonics and liberal diet; locally, after detergent measures, shaving, and epilation, izal was applied as an ointment, composed of equal parts of izal and lanoline. Improvement began in a few weeks, and after three months no more spores could be found. Discharged after twenty weeks in the hospital.

The author considers that the advantage derived from the use of the izal was very noteworthy, especially considering that in Case I. many other parasiticides had failed. It should be noted that izal, though non-poisonous, is a stimulant and may prove an irritant.

J. A. ORMEROD.

GRANULOSIS RUBRA NASI (JADASSOHN). WALTHER PICK. (*Archiv f. Dermat. u. Syph.*, September, 1902, p. 105.)

THIS peculiar affection of the nose, which until recently had been passed over as dysidrosis, a type of eczema, a variety of Lupus erythematosus and the like, was first recognised as an entity by Luithlen, who described it as "Acne associated with changes in the sweat-apparatus." But it is to Jadassohn that we are indebted for the first careful description of it. He observed seven cases and gave it the above name. Ten cases of the same affection have also been reported from Neisser's clinic by Hermann under the heading of "A Peculiar Inflammatory Dermatitis of the Nose in Young People." As this disease has not yet been generally recognised as an entity in this country, the following short account of an additional case will doubtless be of interest.

The patient was a girl, aged 11 years, who was brought to the Dermatological Clinic at Prague in October, 1901, and in whom the disease had existed for two years. When she was first seen there was a clearly demarcated triangular lesion on the nose involving the alæ and the tip and extending upwards to the middle of the anterior border. The skin of the affected area was intensely red, slightly infiltrated and dotted over with beads of perspiration. It had a damp, glistening appearance, and the sweat was clear and faintly alkaline in reaction, as it usually

is in excessive sweating. Besides the beads of perspiration the diseased skin presented numerous red or brownish-red discrete papules varying in size from a pin's-head to a hemp-seed. These papules had no central opening and were not connected with the sweat-pores. There was no scaliness, telangiectases or atrophy associated with the diseased patch.

Besides this affection of the nose there was hyperidrosis of the palms of the hands and slight Lichen pilaris on the extensor aspects of the arms. The general health was unimpaired. Under treatment with ichthyol liniment and salicylic plaster the patient was so far improved in a month as to be able to be discharged, but the hyperidrosis continued, and the disease gradually returned and has since proved intractable. A piece of the skin was excised from the nose and examined microscopically. The epidermis was not definitely altered, but the corium showed evidence of an acute dermatitis, with dilatation of the blood-vessels, cedema, and an inflammatory infiltration chiefly localised around the sweat-apparatus, the ducts and coils of which were widened.

The clinical and histological appearances described in this case were identical with those which Jadassohn found to be constant in all his cases.

The writer discusses the differential diagnosis of this affection. It is distinguished from Rosacea by the age of the patient and by the absence of telangiectases, and of changes in the sebaceous glands; from Lupus vulgaris by the histological architecture; and from Lupus erythematosus by the absence of scales.

J. M. H. M.

ON LINEAR ERUPTIONS. J. BERTAMINI. (*Archiv f. Dermat. u. Syph.*, September, 1902, p. 85. Three Plates.)

THE writer here communicates a case of linear eruption which occurred in a woman, aged 46 years. The disease began eight months before she presented herself at the Dermatological Clinic at Graz. It was confined to the left side of the body and involved the skin of the abdomen, lumbar region and lower extremity. It began below the umbilicus on the left side of the abdomen as a confluent plaque about the breadth of the hand and made up of hemp-seed sized papules, many of which were excoriated and covered with crusts. This plaque spread round towards the lumbar region.

On the left lower extremity there was a line of eruption about half a c.m. in breadth, extending from the middle of the left labium majus and passing down the inner side of the knee to the internal malleolus, and then gradually fading away on the inner side of the foot. This linear lesion closely corresponded to Voigt's line and had a brownish tinge, being made up of brownish flat papules and macules about the size of hemp-seeds. The eruption had begun with erythematous patches, which showed a tendency to vesiculation.

A piece of skin from the linear lesion on the leg was excised for microscopical examination and showed an infiltration of young connective tissue-cells, endothelial-cells and a few mast-cells, with dilatation of the superficial vessels of the corium. Acanthosis was present in the epidermis. Marked cedema was evident in and between the prickle-cells and there was a condition of "spongy metamorphosis." A vesicle was present in the epidermis. It was situated superficially in the site of the transitional layers. At the base of this vesicle were several swollen

homogeneous bodies like psorosperms; these the writer regarded as degenerated prickle-cells.

From the clinical appearance of the eruption and the histological changes which were detected the writer concluded that the case was one of Lichen planus associated with vesiculation. The causation of linear eruptions in general was also discussed.

J. M. H. M.

ON SPONTANEOUS AND SCAR KELOID. M. A. CHLENOV. (*Russ. Journ. of Skin and Ven. Dis.*, 1902, July, August, and September.)

THE author gives a very full account of the views held by dermatologists as to the nature and classification of keloids. He describes a case of spontaneous keloid which he examined. The patient was a young man, 18 years old, who had 481 keloid tumours: on the body 270, on the upper limbs 87, on the lower limbs 60, on the genitals 14. The treatment was as follows:—Baths (93° to 100° F.); inunction with an ointment composed of lanolin and soft soap, equal parts; then inunction with a 30 per cent. resorcin ointment; hypodermic injections of arsenic (sixty injections of a 1 per cent. solution), and light-treatment by means of a Lortet and Genoud lamp. The resorcin ointment appeared to soften the tumours, and the light-treatment had no effect on one tumour, and the other grew distinctly larger; but only two applications were made to each of the two tumours treated by light.

The conclusions the author comes to are as follows:—

1. Hypertrophied scars should not be included amongst the keloids.
2. The distinction between primary and secondary keloids cannot be strictly maintained, either clinically or histologically, but it may be convenient clinically.
3. The histological changes in keloid consist in hypertrophy of the fibrous tissue (with destruction of the elastic tissue) along the blood-vessels.
4. The chief cause of the appearance of keloid is a special predisposition of the individual, family or race.
5. The diagnosis is, on the whole, bad, and the treatment is unsatisfactory.

WILLMOTT EVANS.

A MILDLY INFLAMMATORY CONDITION OF THE SKIN COVERED BY GREEN SCALES, PROBABLY PRODUCED BY B. PYOCYANEUS. MARTIN F. ENGMAN. (*Interstate Med. Journ.*, August, 1901.)

THE patient, a man aged 32, with Alopecia pityrodes, complained of a greenish scaly eruption on the side of the scrotum, the upper part of the thigh, and the perineum. The part chiefly affected was the left side. He wore a suspensory bandage, and noticed a green stain upon it. This stain was worse when he sweated freely. There was some slight inflammatory change in the epidermis. Some of the green scales were examined, and *B. pyocyaneus* was found to be present.

The writer concludes that as it was evidently not due to malingering, and as *B. pyocyaneus* was present, therefore it was due to the latter.

[The question of it being possibly due to a dye in the suspensory which was dissolved by the sweat does seem to have been considered, and mention is made that the suspensory bandage had frequently been washed, and therefore

could not be the cause; but this is not quite enough. There is no statement as to its colour, or whether any attempt was made to try the effect of an acid solution upon it. As the green colour was limited to regions in contact with the suspensory bandage, we are inclined to think that this possible explanation must be negatived absolutely before assuming *B. pyocyaneus* as the offender.—A. H.]

ARTHUR HALL.

THE PATHOLOGICAL ANATOMY OF VERRUCA PERUVIANA ("VERRU-COME DE CARRION"). ESCOMEL. (*Annales de Derm. et de Syph.*, November, 1902, p. 961.)

THIS is an elaborate and most beautifully illustrated paper, no fewer than fourteen chromo-lithographs of exceptional merit being included with it. Much of the previous literature on this subject has emanated from the Lima school. This is reviewed very fully. The conclusion arrived at for the most part was that these nodules were in reality fibro-sarcomata. The disease is found only in certain parts of Peru. The incubation-period varies between fifteen and forty days. The early symptoms are those common to infectious diseases—namely, lassitude and articular and muscular pains; fever supervenes and may reach a height of 40° C. and even more; there is rapid and profound anæmia; the spleen, liver, and lymphatic glands are enlarged; this stage has a very inconstant duration and may end either in death, or recovery (acute type), or the eruption of verrucæ (chronic type). The identity of the acute-febrile and the eruptive-chronic types was established by Carrion, a student of medicine who lost his life in the experiment which proved this fact. His name may therefore fitly be associated with the disease.

In the eruptive form, after the premonitory febrile symptoms, numerous small elevations appear, better felt than seen, usually on the limbs, and on the extensor surfaces of these. The face is not spared, and the trunk is affected, but to a less extent. Two kinds of verruca are described, the miliary, and a larger, which, owing to its being the rule in mules affected with the disease, is called by the natives "verruca mulaire." Both kinds may occur simultaneously in the same case. In the miliary eruption, which is the commoner, the skin has the appearance of being covered with small ripe cherries. The lesions may be confluent or isolated. Occasionally only one large swelling may be present, the size of an orange, with a superficial resemblance to cancer. The eruption may occur acutely, or in successive crops. After a time the eruption disappears, leaving no traces. In only one case was a black pigmentation noticeable in the position of previous lesions. With the eruption the fever falls, the liver and spleen diminish in size, the pains vanish. Where the fever persists, the prognosis is grave.

Having made these general observations, the author proceeds to give a detailed analysis of the disease under these heads:—(1) Definition and classification; (2) Macroscopic characters at periods of (a) evolution and (b) involution; (3) Localisation; (4) Microscopic characters at periods of (a) evolution and (b) involution; (5) Histogenesis and course. Cellular theory; (6) Micro-organisms observed.

The classification, according as smaller or larger tumours prevail, has already been noted. The naked eye characters vary according as the lesion is recent or old. It begins usually as a circumscribed macule, or a nearly invisible papule. It grows slowly in size and becomes red, forming a small tumour which is either sessile or pedunculated. In the small-tumour variety the lesions may be either

warty, vesicular with umbilicated centre, or pustular. The two latter eventually become verrucose. In the larger tumour the skin atrophies by the pressure forward of the subjacent granuloma, and this finally becomes forced through the skin "like the glans penis projecting from the preputial fold." These may be single or numerous; their colour, before the skin is altered by pressure, is either that of the surrounding skin, or it is red or blue. The consistence of the early swellings is something between that of a fibroma and a myxoma. In its involution the tumour begins to waste, becomes paler, and the most prominent part of it becomes scaly; it decreases by desquamation, and all trace of it disappears. Occasionally hæmorrhages, necrosis and suppuration occur in the tumours, but these are exceptional terminations.

Localisation.—Any part of the body in which there is connective tissue may be affected. The corium and the subcutaneous cellular tissue are the sites of election, but the tumours may occur also on the meninges, the conjunctiva, the naso-pharynx, the intestinal mucosa, the bronchi, pleura, muscles, liver, spleen, pancreas, &c.

Microscopical characters.—The methods of staining recommended are as follows (after Ramón y Cajal):—

1. The sections are immersed for five to ten minutes in a concentrated or saturated solution of magenta red.

2. Rapid washing in water.

3. Five to ten minutes in the following staining solution:

Saturated solution of picric acid in water	100
Indigo carmine	0.25

4. Rapid washing in water acidulated with acetic acid, a few crystals of picric acid being added.

5. Decolourise in absolute alcohol, until excess of stain is removed, indicated by the sections assuming a violet colour.

6. Clear in Xylol or Bergamot oil. Mount in Canada balsam. In place of magenta red in the process (1) Grenacher's carmine may be used, and the sections kept in this from eight to twenty-four hours. The rest of the procedure is as above.

In the early stages the verruca is made up of embryonic connective-tissue cells, with some leucocytes. Certain cells to which the name of verrucose ("cellules verruqueuses") has been given have been described as occurring in these tumours. These are in no wise special, but occur in all actively proliferating connective-tissue formations. Trabeculæ derived from the connective tissue traverse the tumour, forming meshes containing cells, and enclosing the entire mass of the granuloma. In this stage it contains no blood-vessels. But around the vessels in the neighbourhood of the new growth there is a cellular infiltration, consisting of embryonic cells, leucocytes, and mast-cells. The latter occur in the granuloma only after the development of blood-vessels in it, which occurs as the tumour grows. These are of two kinds, arteries and veins, and capillaries. The tumours may be unilobular or multilobular.

The larger type of tumours histologically resembles the above and the tumour consists of "cellules verruqueuses," mast-cells, leucocytes, blood-vessels, and connective tissue.

As the tumour begins to disappear the cells composing it become altered, the connective tissue gets thinner. There is none of the early obliteration of vessels seen in the granuloma of tubercle.

Escomel regards the granuloma as the result of physiological efforts of the organism to repel the invasion of the parasites which are conveyed by the blood and which escape from the vessels into the tissues. In his sections he found long, thin straight bacilli which he considers to be the cause of the disease. But the subject requires further investigation.

E. GRAHAM LITTLE.

AN UNUSUAL FORM OF SCLERODERMA. E. TEDeschi. (*Gaz. d. ospedali e d. cliniche*, June 29th.)

A MAN, 75 years of age, had noticed patches of hard skin on his legs for five years, and there had been acute pain in the limbs, increased by movement, and followed by contraction of the leg muscles, so that talipes equino-varus was produced. Tremor and incoordination of the limbs was present, and patient was subject to convulsions. On the arms, forearms and hands were patches of erythematous, desquamating, dense, inelastic skin, associated with considerable thickening. On the legs were also similar lesions, and below the knees the skin was thickened and inelastic. The electrical reactions of the leg muscles were altered, and reaction of degeneration was present in the muscles supplied by the external popliteal nerve on both sides. The author considers that both the skin-affection and the neuritis were inter-dependent and probably due to a common cause.

J. L. BUNCH.

LUPUS TREATMENT BY LANG'S HOT-AIR METHOD, WITH HISTOLOGICAL EXAMINATION OF THE EFFECTS OF HOT AIR UPON HEALTHY AND DISEASED SKIN. L. SPITZER. (*Zeitschr. f. Heilkunde*, XXXIII., p. 6.)

LANG's apparatus is similar in principle to Paquelin's cautery and is heated by benzine, and the application of this method is not followed by unpleasant consequences to the patient, nor is albumen found in the urine as a result of its use. Its advantages are:—(1) Rapid healing. (2) Good cosmetic effect. The scars are smooth, and soft, and supple. (3) Possibility of application to even large areas. (4) Simplicity and ease of application.

Should more than one application be necessary, this does not exclude hope of a successful result and lasting cure.

J. L. BUNCH.

SYPHILIS AND WOUNDS. MAX STERN. (*Wein. klin. Rundschau*, October 19, 1902, p. 809.)

ACCORDING to Neumann, the majority of surgeons is of opinion that syphilis does not affect the course of most wounds, operations and fractures, although plastic operations are often unfavourably influenced by the disease, if still active, leading to ulceration of the transplanted skin-flaps. Neumann states that "the wounds of syphilitics which extend into healthy tissue heal normally if additional lesions be avoided, but if the wound touches a syphilitic infiltration this becomes stimulated by the irritation of the wound to proliferation and ulceration." Stern quotes two cases which show that this rule, if it be one, has exceptions. In the first case, a man of 20, who came under treatment for chancre and was ordered to

return in six months for a second mercurial inunction cure, omitted to present himself for this additional treatment. Twelve months after the primary affection he injured his thumb with a sharp piece of iron wire, and as a result of this accident an extensive phlegmonous inflammation of the hand and forearm developed. In spite of incisions, irrigation and careful surgical treatment, the inflammation and discharge increased, and it was found impossible to alleviate the patient's condition until Stern, in view of the previous history, ordered an inunction cure. From this time the arm improved and rapidly healed. The second case was somewhat similar. A youth of 17½ developed inflammation and ulceration of one finger as a result of a slight abrasion of the skin. The usual surgical treatment did not improve matters, and, after considerable pressure, he owned to having a chancre on the penis, which had been present for fourteen days. An injection cure of 2 per cent. hydrarg. perchlor. solution with local treatment of the finger was successful in healing not only the chancre but also the finger. The influence, therefore, of syphilis, whether active or latent, on otherwise trivial lesions of the skin may be extensive and far-reaching, and only to be combated by adequate and thorough specific treatment.

J. L. BUNCH.

NOTICE.

FIFTH INTERNATIONAL DERMATOLOGICAL CONGRESS.

TO BE HELD IN BERLIN FROM THE 18TH TO THE 17TH OF SEPTEMBER, 1904.

THE following three subjects are suggested for discussion by the Committee of Organisation:—

- (1) The Syphilitic Diseases of the Circulatory Apparatus.
- (2) The Skin Affections associated with Abnormal Metabolism.
- (3) The Forms of Epithelioma and their Treatment.

(Signed) The Secretary-General, O. ROSENTHAL.

W., Potsdamerstrasse 121 g,
Berlin.

PLATE I.

BEFORE TREATMENT

TO ILLUSTRATE DR CHALMERS WATSON'S CLINICAL NOTE ON VERRUCA PLANA.

PLATE II.

AFTER TREATMENT

TO ILLUSTRATE DR. CHALMERS WATSON'S CLINICAL NOTE ON VERRUCA PLANA

THE BRITISH JOURNAL OF DERMATOLOGY.

MAY, 1908.

LUPUS ERYTHEMATOSUS: SOME ILLUSTRATIVE CASES.

By WILFRID B. WARDE, M.D., M.R.C.P.,

Assistant-Physician to the Blackfriars Hospital for Diseases of the Skin.

In September of last year I pointed out in the *British Journal of Dermatology* (1902, p. 332) the frequent association of the disease known as Lupus erythematosus with hypertrophic and atrophic Rhinitis, with or without ozæna. In December of the same year (Journal, p. 447) I was enabled, by the courtesy of the Editor, to express the following views concerning the disease in question:—

1. That Lupus erythematosus is not a distinct pathological entity, but merely one instance of a common process frequently met with in a certain class of individuals, atrophic Rhinitis being another.

2 and 3. That the essential and, in rare instances, the only symptom is a pernicious œdema, due to a paralysis and dilatation of the small blood-vessels, and apt, unless removed by treatment, to end in their complete destruction, together with the granulation tissue that has formed round them with a view to the repair of the damage done.

4. That the œdema and vascular degeneration depend (a) *indirectly* on a feeble circulation, leading to a state of malnutrition of the vessel walls, on strain placed on the vessels by flushing, on anatomical conditions, in that the skin is thinly stretched over unyielding parts and on other known or unknown causes; (b) *directly* on any cause capable of producing a surface œdema such as exposure to heat and cold, burns, and the presence on the skin of various

efflorescences due to poisons, certain fevers, microbic activity, and to other known or unknown causes.

I endeavoured to show that such common diseases as Eczema, Psoriasis, Alopecia, Sycosis, the various Erythemata, Lupus vulgaris, Syphilis, and probably many others, might determine the changes in certain predisposed individuals, and by so doing undergo a marked change of type.

Since the appearance of this last communication I have again examined my list of cases, and have in addition collected the cases of Lupus erythematosus reported in the Journal for the last seven years. I propose to quote some of these cases in support of the theory I am advancing.

My first discovery was that my theory of the disease had been to a certain extent anticipated.

Dr. Galloway (*Brit. Journ. of Dermat.*, 1899, p. 288) reports a case of Erythema multiforme passing into Lupus erythematosus, and makes the remark "that the *scar-leaving erythemata* were of various origins, and that the thesis so recently advanced—namely, that they were all of remote tuberculous origin, would not bear critical examination."

I was unaware of the existence of this statement at the time when my paper appeared, and believed the theory I advanced to be entirely novel. I confess to a feeling of great satisfaction that the views I hold are, in part at least, shared by an observer like Dr. Galloway.

In the September number of the Journal (1902, p. 380) I showed that the mucous membrane of the mouth was affected in eight out of fifteen cases, and that three of these exhibited an atrophy of the membrane covering the hard palate. In one case there was marked thickening of the stratified epithelium, which appeared sodden and raised in folds, as if ready to exfoliate.

CASE 1.—Exhibitor, Dr. Galloway. (*Brit. Journ. of Dermat.*, 1901, p. 7.)

Female, aged 52, duration nine months. On the hard palate an erythematous area of mucous membrane covered in patches by macerated and desquamating epithelium. Buccal mucous membrane very superficially ulcerated. Lupus erythematosus of face and hands.

The next case illustrates the passage of ordinary chilblains into permanent erythematous lesions.

CASE 2.—Exhibitor, Dr. Pringle. (*Brit. Journ. of Dermat.*, 1895, p. 115.)

Female, aged 28. For five years recurring chilblains, which cleared up entirely in summer. During last four years traces of the disease have persisted throughout the summer in the form of erythematous infiltrated discoloured patches on the hands. Hands and feet always either hot or cold. Ears burn and are congested. Face showed patches of erythema with seborrhoea and desquamation (seborrhoea congestiva) over tip of nose, malar prominences and lobules of the ears.

Those in flush patch persistent for a year, the others said to disappear from time to time. No signs of scarring.

The livid, infiltrated, well-defined lesions on the hand described in this case are not uncommonly met with and the condition has received a number of names. I fail to see why it should be so carefully separated from Lupus erythematosus. In this case the lesions had not ulcerated; but it is extremely common for them to undergo a central necrosis, and to heal with the formation of a small conical pit.

When I examined the condition of the ears in my first fifteen cases, I found that this same induration, followed by necrosis and formation of pitted scars, was inseparably bound up with the disease. The following cases bear on this point:—

CASE 3.—Exhibitor, Dr. Stephen Mackenzie. (*Brit. Journ. of Dermat.*, 1898, p. 10.)

Female, aged 24, duration three years. In the winter, three years ago, four or five bumps on the hands that festered and burst. Two years ago the hands became white and cold on washing and then almost black. She has local asphyxial attacks on the hands almost daily. Ears only once attacked. Edges of pinna rough and dark coloured. On both elbows four to five discoloured patches. The earlier ones are purplish red, and in the centre is a dry white necrotic area. The later spots are brighter, slightly indurated and tender. Similar spots on wrist and right side of the bridge of the nose. Typical Lupus erythematosus of scalp. No ulceration there in the past.

CASE 4.—Exhibitor, Mr. Malcolm Morris. (*Brit. Journ. of Dermat.*, 1897, p. 234.)

Female, aged 22. Whole top of head composed of scar tissue. Most of it thin, depressed and white. Here and there small patches red and infiltrated. *History of lumps coming on scalp, which burst, discharged freely and then cicatrised.* The cicatrices increased in size. Eight weeks ago florin-sized patches appeared over each malar prominence—not raised, felt hard and nodular. A similar ring-shaped patch lower down on right cheek.

This case corresponds very closely to one (40 M.) in my first series.

I saw a large pus-collection on the scalp. It discharged with the formation of a thick foul crust, after the fall of the crust a typical Lupus erythematosus scar remained, which in course of time increased in size. In this case also I saw ordinary festers on the hands become converted into atrophic erythematous lesions. The child also had a typical atrophying butterfly erythema on the nose and cheeks. The case proved to me that a common pus-infection could produce a lesion on the scalp and hands not to be distinguished from ordinary Lupus erythematosus and brought the conviction that the conception of the disease must be enlarged so as to include this as well as other and kindred manifestations.

CASE 5.—Exhibitor, Dr. Stephen Mackenzie. (*Brit. Journ. of Dermat.*, 1898, p. 256.)

Female, aged 24, duration thirteen months. Scaly erythematous patches on face. Some discoid, depressed and capped. Typical patches on scalp, on the front and back of the chest, small depressed superficial scars, and on the back patches of follicular inflammation with some keratosis. Eruption on chest and back resembled the remains of *Acne varioliformis*.

CASE 6.—Exhibitor, Dr. Eddowes. (*Brit. Journ. of Dermat.*, 1901, p. 182.)

Female. Noticed lumps, like chilblains, forming on her hands. Did not disappear in summer though less conspicuous. Central plug formed in each nodule, which on falling out disclosed a pit like small-pox. On the lobe of each ear a considerable number of small deep pits formed a cicatrised patch, in each case surrounded by a red scaly advancing border. Dr. Crocker, who saw the case, considered the eruption on the hands to be *Folliclis*, that on the ears Lupus erythematosus, the two not being connected, though he had a case with a similar association of the two affections at present under treatment.

CASE 7.—Own collection.

Female, aged 19, duration one and a half years. When first seen she had a large ring on each cheek. The centre was white, looked atrophied, and showed several peculiar rounded depressions, about the size of a lentil. The border was red and œdematous, the horny layer being in places lifted up by a serous discharge, or actually removed, leaving moist spots. She had a typical chilblain circulation; swollen, shiny blue nose; hands deep red and swollen, with livid erythematous patches. In addition she suffered from hypertrophic rhinitis with ozæna, mucous catarrh of pharynx and adenoid hypertrophy, and atrophy on the hard palate. The case improved under treatment, the rings faded and disappeared, leaving a glossy condition of the surface skin, but no obvious atrophy. Shortly after she had a relapse on one cheek. I found a pea-sized yellow slough, not raised and clearly involving the whole thickness of the epidermis. The slough was surrounded by an erythematous ring that began to extend at the periphery, healing

in the centre, till the ring was as large as when she came first under notice. The central slough separated, leaving a depression similar to those noted at first. On this occasion the erythematous ring was more indurated, and it still persists as a deep red, slightly scaly circle within which the skin is white and glossy. The necrosis resembled that met with in acne varioliformis, and I have no doubt was of the same nature ; but owing to the disposition of the patient it determined an atrophying erythema in the surrounding parts.

Later on in November the patient developed a large number of chilblains on the hands. It was interesting to notice that all the former lesions of the hands had disappeared, and in only one instance had a scar resulted. That was a *raised* oval perfectly white patch with its surface studded with minute pits, a cribriform raised scar such as one encounters in certain cases of acne, and more particularly in the lower dorsal and lumbar regions. I hope to deal with this particular class of cases on some future occasion, and only advance this point now to emphasize my opinion that many of the atrophying and scar-leaving eruptions are not separate and distinct disorders, but represent the operation of certain pathological laws on common and, in some instances, well known skin-affections.

The next case bears a certain resemblance to the last.

CASE 8.—Exhibitor, Dr. Cavafy.

Female, aged 24. For the last two years severe chilblains on ears, fingers, toes. One year ago red spots appeared in succession on the cheeks, slowly extended and faded in two months. Two and a half months ago large hard red patch on right cheek. Patch slowly extended at margins, clearing in centre to form a ring with hard red border and practically normal centre. Lobes of ears shrunken and rough.

The following cases illustrate the view I put forward that the distribution of lesions was largely determined by anatomical conditions and particularly by the presence of a bony ridge or unyielding bony or cartilaginous surfaces.

CASE 9.—Own collection.

Female, aged 36. Extensive scarring on scalp. Patches on face limited to left supra-orbital ridge, bridge of nose, close to inner canthus of right eye. Mastoid process on right side.

CASE 10.—Own collection.

Female, aged 26. A rough erythematous patch covering one malar bone and extending as narrow bands along the zygoma and infra-orbital ridge.

CASE 11.—Own collection.

Female, aged 39. Three typical atrophying erythematous patches on face. Two beneath the left eyelid exactly corresponding in line to the infra-orbital ridge. The third is about the size of a pea and exactly coincides with the small lacrymal tubercle, the patch being internal to and just a little above the inner canthus of the right eye.

In view of this peculiar distribution the following case seems to be suggestive:—

CASE 12.—Exhibitor, Dr. Perry. (*Brit. Journ. of Dermat.*, 1896, p. 223.)

Male, aged 28. A *short distance below* the eyelid a patch of superficial scarring, rough and scaly in centre, with margin showing dilated vessels.

Some time ago I saw a remarkable case in which the disease commenced on the bridge of nose, extended as a band along the infra-orbital ridge, spread out to form a patch over the malar prominence, extended as a band along the zygoma, missed the ear and reappeared on the skin covering the mastoid process.

I have lost all trace of the case and have only the recollection of the remarkable distribution, which at the time I could not explain.

I now come to a type of case that has interested me considerably.

CASE 13.—Own collection.

Boy, aged 14. Duration, eight weeks (?). Has had a dry skin all his life with red flecks on the cheeks. Eight weeks ago the present eruption appeared on the scalp. Owing to the loss of hair and abundant asbestos-like scales it was thought to be a ringworm; but a careful examination showed that no fungus was present. When the head was shaved it could be seen that the disease consisted of an atrophying follicular condition accompanied by extreme hyperkeratosis. There were dry sunken atrophied patches scattered over the vertex. Each hair was surrounded by a horny collar that dipped down deeply into the follicle. The skin in front of each ear, extending on to the cheeks, is studded with tiny pits, each pit marking a follicle. The condition resembles the orange-peel condition of the nose and centre of face met with in older persons. Skin of arms red and rough, showing keratosis of follicles. Palms of hands dry and hard.

CASE 14.—Exhibitor, Dr. Crocker. (*Brit. Journ. of Dermat.*, 1896, p. 140.)

Female, aged 14. Duration, one year. Healthy well-grown girl with rather defective circulation, hands and lips becoming blue in cold weather. Disease extends all over both cheeks as far as a line 1" from nose. Slight reddening of patches due to dilated vessels, but chief lesions are minute cribriform atrophic pits, *so closely aggregated in places as to form minutely reticulated, superficial scars*. No comedones present. Exhibitor regarded it as an unusual form of Lupus erythematosus.

CASE 15.—Exhibitor, Dr. Colcott Fox. (*Brit. Journ. of Dermat.*, 1896, p. 220.)

Female, aged 18. Minute cribriform pits as closely packed as possible over the greater portion of cheeks. *Nose, eyelids, chin, forehead spared*. No telangiectases. No comedones. With the lens some minute hyperæmic conical

papillæ, seated on follicles, but otherwise no eruption answering to keratosis pilaris. Diagnosis: Folliculitis with subsequent atrophy.

These cases are clearly closely allied, if not absolutely identical. In my case the keratosis of the scalp was extreme. In the other two it is not much in evidence. The next case throws light on the others and brings them into line with Lupus erythematosus.

CASE 16.—Own collection.

Female, aged 31. Duration, two years. Persistent round œdematous plaque on right cheek about size of a penny. When first seen she had a comedo to the left of the nose. Suffers much from chilblains of hands, feet and ears.

At a later date it was noted that the comedo had disappeared, leaving a fairly deep rounded pit. In the very cold weather before Christmas I noted a small irregular patch on the left cheek, marked merely by dilated vessels. The orifice of each follicle was occupied by a pin-point yellow crust or plug. On January 22nd of this year I noted that every follicle in the reddened area was represented by a minute pit. At the same time there was a faint red mottling of the lateral part of each cheek, and in this red area there were patches in which every follicle was marked by a brownish-yellow plug of pin-point size. The follicles in this area either projected very slightly or were level with the surface. With good illumination the picture was most striking, a multitude of dark points on a reddish-yellow background. It was clear that the atrophy going on in the older patch would extend to these surfaces, and there was already produced on one spot the cribriform lesion noted in the preceding cases.

The special interest of this case is that she showed on the scalp above and anterior to the ear the keratosis pilaris so frequently encountered in cases of Lupus erythematosus.

In forty-one cases where I was able to make a careful examination of the scalp, I found indurative erythema with cicatricial alopecia fourteen times, and in the remaining twenty-seven cases, three showed Keratosis pilaris*; six showed Alopecia pityrodes in an extreme form; two showed seborrhœa of the scalp with a band of alopecia running across the forehead.

It is not surprising to find in cases of Lupus erythematosus, amongst whom marked circulation anomalies are so common, evidences of malnutrition in places other than the face and hands. The more closely I examine these cases the more evidence I find to show that simple lesions, such, for instance, as a folliculitis, a

* By Keratosis pilaris I mean a conical elevation surrounding the hair and quite devoid of colour, usually present in the scalp above and in front of the ears and attended by slight hyperkeratosis. By Alopecia pityrodes I mean an exaggeration of this condition in which the hyperkeratosis is extreme, and most of the hair has broken off near the scalp, which is dry, rough and scaly.

comedo, a pustule, an erythematous patch, a vesicular eruption, a scaly macule, &c., are apt to produce an atrophy and leave a permanent mark owing to the malnutrition of the parts affected.

In many cases the first eruption may clear off without leaving any apparent trace; but it is specially apt to return. With each relapse the damage done and the persistence of the lesion both increase till at length a practically incurable disease results. The case recorded by Mr. Pernet for Dr. Crocker (*Brit. Journ. of Dermat.*, 1902, p. 429.) is one amongst many in support of this.

CASE 17.

Male, aged 18. Duration, two years. Disease commenced in summer time on the face as a butterfly eruption, spread to ears, neck, chest, abdomen, back, arms, hands and feet, both palms and soles being involved.

The tongue was affected and there was transient albuminuria. There was rapid improvement under salicin, so that at the end of a month there was not much to be seen except two small areas on the right cheek and another on the left, with some dusiness of the skin of the face, but very little of the body.

Cases of this type are not uncommon. They seem to belong of right to the exudative erythemata and it is not at all surprising to hear that they are benefited by salicin. They are frequently associated with albuminuria, occasionally with actual nephritis, and are apt to suffer from hypertrophic rhinitis, enlargement of the tonsils, severe affection of the mucous membranes of the mouth, otitis media and perforation of the tympanum. In some instances the eruption has assumed a bullous character and some have ended fatally.

A careful study of the many exudative eruptions and a grouping of the same will, I feel convinced, make many points in the ætiology of Lupus erythematosus clearer than they are at present.

In conclusion, I again state my conviction that Lupus erythematosus is not a disease, but merely a stage in the course of many different affections—a step in the pathological ladder by which a damaged part, unable to achieve its own repair, is destroyed and replaced by fibrous tissue. In a certain class of individuals the repair is indefinitely prolonged, till it may appear to be altogether postponed, and then the condition becomes known as Lupus erythematosus.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of the above Society was held on Wednesday, April 8th, 1903, Dr. GRAHAM LITTLE in the Chair.

The following cases and specimens were shown:—

Dr. S. E. DORE showed a case of *Lupus erythematosus* associated with Angio-keratoma and Erythema induratum, which will be published *in extenso* in a future issue.

Dr. GRAHAM LITTLE showed (1) a case of *Nævus unius lateris* in a boy, aged 7. The affection was congenital and unilateral; the streak extended from the pubic arch, along the inner side of the thigh and leg to the instep on the right side. The upper part of the streak was verrucose and deeply pigmented, and the affection extended on to the inner side of the scrotum exactly in the position of the small scrotal flap assigned to the second lumbar by Head (Allbutt's "System of Medicine," Vol. VIII., p. 626). It was here also very warty and black. In the middle of the streak, as it descended the inner side of the leg, the verrucose character disappeared, but the pigmented line continued unbroken, to become again verrucose below the knee. The line was remarkably uniform in cross section, being about three-eighths of an inch wide. It seemed to correspond to the distribution of the second, third and fourth lumbar segments as mapped by Head (*loc. cit.*). There was a model in the St. Louis Museum, of which a drawing appeared in *La Pratique Dermatologique*, in which the distribution was extraordinarily similar. (Catalogue, No. 1,381.)

(2) A case of a *rodent ulcer* developing in the site of a mole in a woman of 50. The following history was obtained:—The mole, which was on the left cheek about half an inch below the eye, had been present as long as the patient could remember, but six years ago she had had an accident in which a hat-pin pricked it deeply. There was no suppuration, but it became and continued painful and swollen.

It was seen by Dr. Macmillan, of Detroit, and excised. The wound healed by first intention, but the growth recurred and became painful and was again excised fifteen months later. It had now returned and was the size of a threepenny piece. She had also had a tumour of the breast, and the latter had been removed on a diagnosis of malignancy about eight years ago, two years before the appearance of malignancy in the mole.

(3) A case of *secondary Syphilis* in a young man aged 20. The case had been sent to St. Mary's Hospital by Dr. Ward Ramsay, who kindly attended the meeting and gave the earlier history of the case. This was as follows:—He was first seen in the second week of November, and had then a much swollen prepuce, apparently concealing a hard sore. This was evident a fortnight later. He developed a sore throat in the first week of December. He was put on 20 minim doses of perchloride of mercury from the date of the first visit. The face became affected about Christmas, and he was then given 10 grain doses of pot. iod. with the mercury. He has been taking this mixture ever since. There is at the present time a very extensive eruption of tubercles and nodules covering the back and front of the body and, less thickly, the backs of the thighs. A remarkable feature was the number of depressed pigmented scars which were being left by the earlier lesions, and the extensive involvement of the face. The apparent failure of the specific treatment to arrest the disease in any way during three months of trial was noteworthy. There was polyadenitis and considerable general depression.

Mr. GEORGE PERNET showed an extensive case of *annular and gyrate syphilide* from Dr. Radcliffe-Crocker's clinic. The patient was a married woman of 32, who gave a history of a sore of the vulva dating from a week before Christmas, 1902. The rash had been present seven weeks and had commenced on the upper part of the chest. It now occupied chiefly the face, back and extensor surfaces of the limbs. The eruption was in the form of rings, with a scaly infiltrated border, the central parts being clear except for a brownish macule in the centre. On the face these rings by coalescence had formed very characteristic gyrate patterns. The case was one of the so-called psoriasiform syphilides, and the psoriasiform appearance

was very marked about the elbows and knees, where these scaly patches looked very like psoriasis. The palms and soles were free. There was ulceration at one angle of the mouth, and ulcers on the tongue and tonsils. Post-sterno-mastoid adenitis was present.

Dr. SEQUEIRA showed (1) two sisters, Jewesses, aged respectively 10 and 7 years, suffering from *Lupus erythematosus*. The elder child had previously been shown at the Society. The lesions in her case were widely distributed, the nose, cheeks, ears and scalp being involved. When she was last before the Society there was albuminuria, but the urine had been free from albumin for some months. In this case the disease had been present for two years. In the younger child the lesions were confined to the "flush" area on the cheeks. They had been present for two months. There was no albuminuria. There is no history of tuberculosis in the family, and both children are free from any evidence of tuberculous disease. They both suffer from blueness of the extremities and during the winter months from chilblains.

In connection with these cases, Dr. Sequeira remarked that he had under observation two sisters of another family, not Jewish, aged respectively 28 and 26, both of whom suffer from discoid erythematous lupus. In these cases also there is no history or evidence of tuberculosis in the patients or in their family, and there has never been any albuminuria.

(2) A single woman, aged 32 years, suffering from circinate superficially *ulcerating lesions* on the palm of the left hand. The patient was born in Jamaica and had lived there for twelve years. Shortly before leaving the West Indies the lesions had appeared on the hand and they had never healed. The appearance of the ulcerations and their situation were those of a syphilide, but the point of special interest was their origin at the age of twelve years and their persistence for twenty years. There was no other evidence of congenital syphilis.

Dr. WHITFIELD showed a specimen from the scrotal tumour of the case shown by Dr. Parkes Weber at the last meeting. The piece of skin excised showed a mass of infiltration nearly half an inch in thickness. Microscopically the tumour was seen to be composed of

chronic inflammatory infiltration into the corium and subjacent muscular tissue. The epithelium was secondarily affected, the inter-papillary ridges extending very deeply into the corium, while the supra-papillary epithelium had almost disappeared; otherwise beyond slight œdema there was nothing worthy of note. The whole thickness of the corium was thickly infiltrated with cells, of which by far the greater proportion were of the lymphocytic type; some plasma- and epithelioid cells were present, but only in relatively small numbers. There were also well-formed giant-cells scattered through the mass, and there was naturally a slight tendency for them to be surrounded by epithelioid cells. There was, however, none of the nodule formation usually associated with tuberculosis and the enormous lymphocytic infiltration was also against it. On the other hand the normal fibrous tissue had almost entirely disappeared before the invasion of the small cells. A great deal of new formation of vessels was seen, especially in the more superficial parts of the mass, while the older vessels were in many instances the seat of marked infiltration into their walls and outside, and endo-vascular proliferation was not a very marked feature. On the whole the appearances were more in favour of syphilis than anything else, but it was of course impossible to say definitely to what the chronic inflammatory trouble was due. All question of malignant growth was, however, answered in the negative.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, March 25th, 1903, Dr. STOWERS in the Chair.

The PRESIDENT announced that it had been decided to hold a Dinner after the Annual Meeting in May, and that Dr. Corlett, of Cleveland (Ohio), would be entertained as a special guest on that occasion.

The following cases were exhibited:—

Dr. ALFRED EDDOWES showed (1) *a case for diagnosis*. The patient was a girl, aged 11, who had disseminated wart-like lesions of very uniform character, and somewhat pigmented, affecting especially the

temples, the neck and the anterior central areas of the thorax, abdomen, genital region and front and inner portion of thighs. The duration of the eruption, which was spreading, was said to have been four years, that is to say, in the striking distribution and form as at present seen, but the child's mother stated that she thought the original source of the eruption was a spot about the size of a shilling below the left axilla. She said that eleven days after the birth of the child its nurse accidentally scratched that place, and that it afterwards "gathered" and never properly healed. Dr. Eddowes said that he had not yet satisfied himself as to the exact nature of this unusual case. He was still investigating it, and the members would find under the microscope one of the warty papules which showed much parakeratosis with very little change in the cutis. Although he did not look upon the case as one of tuberculosis, he would, if the original sore did not readily give way to treatment, recommend its excision. He was inclined to look upon it as a multiple cystic infection, and it would be interesting to examine under the microscope sections of this original patch.

(2) A man with a condition which he described as a *streptogenic necro-genic folliculo-adenitis*. When he first saw the patient a month ago, the eruption, which was nodular or rather large papular, and confined to the face, suggested a drug rash from bromide or iodide, but a close inspection negatived such an idea. The eruption began by single papules (disseminated about the centre of the face) in October last, when the man felt quite well. The patient said he could not account for the eruption, unless it was possible that he had caught it from a hen which he had dressed with his own hands with simply hot water for a disease which he believed was *roup*. Dr. Eddowes thought from the description of the disease of this hen that the affection was not unlikely to have been impetiginous. The patient had brought the hen with him, and, as the members would see, she had lost her feathers from the parts affected. The hen would be killed and examined. From the patient's face some of the papules had been excised and examined microscopically. It would be seen that they bore a slight resemblance macroscopically to molluscum contagiosum, but they were smaller. From them, nevertheless, could be squeezed out a milky fluid in which colonies of apparently degenerated micro-organisms were present among the

cell-debris. The papules first appeared as small, shotty, tense, sometimes shining, pale or red, deeply seated, sharply defined bodies, without any distinct follicular centre, unless they occupied a hair-follicle, which then obviously formed the centre. The fully-developed papule rose abruptly, like a papule of lichen planus, one or two millimetres above the surface of the normal skin, and was umbilicated. The central depression was occupied by an eczematous crust. The third stage was necro-genic, and left a depressed scar, with frequently a flat bottom and irregular borders, not regularly funnel-shaped as occurs in common acne. On the soft skin of the lower eyelid it assumed the appearance of small cysts. The sections shown under the microscope fortunately demonstrated the sequence of events. A follicle became crowded with a streptococcus, which caused little excitement until it entered the living portion of the epidermis on a level with the hair-bulb. The upper part of the hair-follicle partly escaped the destructive process, but the sebaceous gland became completely destroyed, and with its destruction the organisms appeared to become encysted and disappeared. Several *giant-cells* could be seen in the disintegrating tissues, but these were not held to be of any special importance in the diagnosis. The case would be further investigated. A photograph taken when the patient first came under treatment showed that while a few new lesions had developed most of the old lesions had disappeared. Dr. Eddowes thought it was new to find a streptococcus infecting in this curious manner.

Dr. RADCLIFFE-CROCKER regarded the condition as that described by Tilbury Fox, as disseminated follicular Lupus, and by Barthélemy as Acnitis, and which he himself called Acne agminata. Mr. Pernet had examined a case in which the hair-follicles were affected also, but Mr. Pernet thought the chief lesion was in the sweat glomeruli. Dr. Crocker mentioned that a photograph of such a case appeared in the latest edition of his book.

Mr. PERNET considered this case was one of Acne agminata.* He also referred to a case exhibited before the Society in 1900, by Dr. Abraham,† under the name of anomalous Acne varioliformis, which Mr. Pernet looked upon as belonging to the same class as the present one exhibited by Dr. Eddowes. Mr. Pernet had shown sections of Dr. Abraham's case to the Society.‡

Mr. HARTIGAN showed a young man with *tubercular peri-folliculitis*,

* See Fig. 70, Radcliffe-Crocker's "Dis. of Skin," 3rd Edition, Vol. II., p. 1096. Also *Brit. Journ. of Derm.*, 1902, Vol. XIV., p. 18. and p. 131.

† *Trans. Derm. Soc. G. B. & I.*, Vol. VI., p. 49.

‡ *Trans. Derm. Soc. G. B. & I.*, loc. cit. *supra*, p. 51.

whom he exhibited before the Society a few months previously. He showed it again now in accordance with a wish expressed on the first occasion. The view he then expressed, that it was tubercular folliculitis, was now confirmed by the histological examination. He had not searched for the bacillus.

Dr. GRAHAM LITTLE showed (1) a case of *Lupus erythematosus*. The patient, a woman of 35, gave the following history:—The lesion on the right side of the forehead, which at present is the largest, was also the first, and was noted two years ago. Between its appearance and three months ago several similar patches developed on the hairy scalp, and in the last three months there had been an acute fresh outbreak, and about eight small nummular patches had broken out on the forehead. The patches were circinate and very moderately scaly. There was an attempt at healing in the centre with some doubtful atrophy. On the affected parts of the scalp there was redness and follicular scaling, but no definite atrophy. The patient had had two miscarriages early in her married life, but had subsequently had nine children, who were all living and healthy, and there was no history of syphilitic eruptions. In view of recent observations on this disease, it was interesting to record that this patient had distinct traces of albumin in her urine, and this feature had been constant during the three weeks she had been under notice, and she also had at the present time a somewhat severe rhinitis.

Dr. RADCLIFFE-CROCKER drew attention to the absence of follicular atrophy in the patches on the scalp and considered the case was probably one of seborrhoic eczema.

Mr. HITCHINS thought the eruption was due to syphilis.

Dr. WARDE agreed with the exhibitor that it was a case of *Lupus erythematosus*.

Mr. PERNET was of opinion that no evidence had been brought forward in support of the *Lupus erythematosus* nature of this case. The diagnosis lay between a seborrhoic dermatitis and a syphilide. Judging from the condition of the scalp, it might turn out to be the former.

(2) A woman, aged 56, with a large patch of scaly dermatitis of indeterminate nature, but shown as “probably *seborrhoic Eczema*.” The patch had a sinuous outline, was sharply circumscribed, and covered the upper part of the chest and the lower part of the neck, forming a plaque about six by eight inches in extent. It had

developed from a single small circinate patch which had been noted for the first time six weeks previously. There were four small patches about the size of a shilling at the present time on the upper part of the back. Repeated examinations for tinea had given negative results. In the museum of the Medical Graduates' College there was a picture of a remarkably similar eruption, which was there labelled as being syphilitic, but there was no question of syphilis as regards the present case.

(3) A case of a *chronic ulcer* in an infant aged eight months. The ulcer was on the left cheek close to but not touching the lower lid of the eye. It had persisted for four months and was much indurated and deeply situated in the skin. A careful bacteriological examination of the deeper part of the ulcer had been made by the pathologist to the East London Children's Hospital, and the results at present obtained showed the predominance in the culture of a bacterium which was indistinguishable from the "Klebs-Loeffler bacillus." The granular staining with Neisser's stain, a phenomenon which is usually considered essentially characteristic of the diphtheria-organism, was particularly well-marked. But there was no other symptom of diphtheria in the case, and no infection from it had occurred.

(4) The case shown by him at the last meeting of the Society as a case of "*Urticaria papulosa* simulating lichen planus" in an infant aged 2 years. In the interval since being shown on that occasion the eruption simulating lichen planus had almost entirely disappeared, and in its place a number of typical urticarial wheals and papules had come out and fresh wheals were appearing daily. The urticarial nature of the disease could be no longer in doubt. The child had been treated with a weak tarry lotion and a mixture of rhubarb and soda.

Dr. NORMAN MEACHEN showed a man, aged 28, with *Alopecia areata*. The history was that three weeks ago he went to a barber's and on the second day after his visit he noticed a bald place beginning to come behind the right ear. This quickly spread and other similar patches made their appearance upon the scalp and hairy parts of the face. Numerous "point of exclamation" hairs were visible. He had never had ringworm when young nor any other illness.

Dr. T. D. SAVILL showed (1) a young man, aged 23, the subject of *Erythema pernio*, with vesication. The hands had been extremely red and swollen, and the man had erythromelalgia all the year round. The hands became painful when held down or when put into hot water, and there was present the characteristic itching and tingling. From time to time during the winter sores appeared, of which one could now be seen on the right forefinger. The ears and nose were only slightly affected.

(2) A case described as *Dermatitis papillaris capillitii* (Kaposi), the patient being a man aged 24. The duration was about nine years. Acne keloid was another name given to it. All the characteristics of the disease were present—the characteristic position, the involvement of the hairs, the termination in a puckered raised scar, with numerous comedones around. Great improvement had resulted from simple massage with olive oil.

Mr. A. SHILLITOE showed (1) a case of *Rupia*. A meatal chancre was acquired last autumn, for which he was treated five or six weeks. In February last he was admitted into the Lock Hospital with a chancre at the meatus and extensive rupia.

Many of the rupial scars are now becoming elevated, somewhat resembling the case shown by the exhibitor last November, and which Dr. Leslie Roberts thought to be fibro-cellular growths and not true keloid. This elevation of the scars has only come on since he has been taking iodide of potassium, to which drug Mr. Shillitoe was inclined to ascribe the condition seen. The opinion of members was generally against this view.

The PRESIDENT suggested that if full doses of iodide of potassium did not produce a favourable effect upon the keloid thickenings, the use of thiosinamine in solution should be tried hypodermically (15 to 20 per cent.), which was known to produce excellent results in similar conditions.

(2) A case of *multiple Lipomata*. This case attended the Lock Hospital for gonorrhœa, March 16th, when it was noticed that he had multiple lipomata. The first appeared last July, and they are still increasing in numbers. They are arranged in peculiarly straight lines, over the vertebral column—below each breast, extending into the thighs—and during the last week have appeared on the upper extremities. Urine normal.

Dr. WILFRID WARDE showed (1), for Mr. WARREN TAY, a case with *symmetrical linear Callosities on the palms*, which had existed four years. No adequate explanation of it was forthcoming. The patient, a young woman, was a parlourmaid.

And (2) a case for diagnosis, that of a man who came under his charge three weeks ago. On the scrotum were sharply-raised shining discs, and the condition was confined to the scrotum. When first seen, the surface of each disc was somewhat moist, but next time it was dry, and the lesions gradually became more smooth and shiny. The condition might be either lichen planus or a syphilide; but he could find no evidence whatever of syphilis. At first he thought it was a commencing eczema, but now the disease resembled *Lichen planus*.

(3) A woman with an *ulcer of the leg*, of seven years' duration. Nine months ago a growth commenced in the centre, and it had slowly increased to its present size—namely, that of a small Tangerine orange. It was firm and smooth on the surface. She had been advised to have the leg amputated, and he thought it was wise; but wished to ask members whether it would be justifiable to try the effect of X-rays over a short period. She had already had two applications. It did not appear to be a very malignant type. The growth had not yet been examined microscopically.

The PRESIDENT recommended that a microscopic examination should be made of an excised portion of the new growth, and if the diagnosis of sarcoma was confirmed, amputation should be performed.

CLINICAL NOTE.

CASE OF VERRUCÆ PLANÆ JUVENILES.

By CHALMERS WATSON, M.B., F.R.C.P.E.

THE patient, a boy aged 13, presented himself at Marshall Street Dispensary for treatment of a skin eruption. Dr. W. T. Ritchie, Visiting Physician to the Dispensary, diagnosed the condition as one of Verrucæ, and kindly handed the case to the writer for observation and treatment.

History of the Case.—Spots appeared on the face about six months previously, but it was only in the last three months that they had assumed the warty appearance now present. They appeared to increase in size and number after an attack of influenza to which he was subject about five weeks before he sought advice. Small growths of a similar nature had existed in the hands for a year or more, and a much larger warty growth had been present on each shin for about two years. There were no subjective symptoms other than disfigurement. The patient's general health was stated to be in all respects excellent. The hereditary history furnished no facts of importance.

Present Condition.—The skin of the face, nose and forehead was studded with numerous small flat elevations, varying in size from the head of a pin to a pea (*see Fig. 1*). These were of firm consistence, and their surface presented a delicate pink or faintly yellow tinge. There was a tendency to confluence of the warty elevations on the bridge of the nose, and a linear arrangement on the middle of the cheek, which was ascribed to the results of a scratch received some months previously. The unaffected skin on the lower part of the cheek was rough, dry and slightly scaly.

The Hands showed the presence of a few typical warts (*verrucae vulgaris*) and in addition a number of flat nodular elevations (*verrucae planae*) similar in appearance to those on the face. The latter were of more recent origin.

The Legs.—On each shin there was present a large warty growth, about the size of a small marble. Its surface presented a very characteristic "cauliflower-like" appearance.

The patient's general health was found to be in all respects satisfactory, with the exception of a definite history of constipation, which had existed for the past year.

Subsequent Progress and Treatment.—The case was kept under daily observation for several days, and it was noticed that a distinct alteration in the size and colour of the warts took place. There was a slight diminution in the size of the warts on the face, and a more marked alteration in the colour, which now assumed a faintly yellow tint. With the view of determining the presence or absence of micro-organisms, incisions were made into some of the most prominent warts on the face, and cultures were made at the laboratory of the Royal College of Physicians, Edinburgh. The result was entirely

negative. The photograph (Fig. 1) was taken immediately before treatment was begun. This consisted in the internal administration of a tablespoonful of castor oil, this being given on two occasions during the first week and once each week subsequently. This dose effected very free evacuation of the bowels after each administration. A material improvement in the condition of the face was evident after eight days, and in three weeks the improvement was very pronounced. The warts had now disappeared, the general skin surface being slightly rough with a tendency to scaling (*see* Fig. 2 from a photograph taken after three weeks' treatment). Coincidentally with this improvement of the face, the conditions of the hands markedly improved, all the recent warts having disappeared, leaving only one or two of the common warts on each hand. Three weeks later* the latter also had disappeared. The large wart on each leg (mother warts) had undergone no change.

Remarks on the Case.—The case is a typical example of a rather rare affection, and the special features to which I wish to draw attention are :—

1. The variations in size and appearance of the warts on the face that were observed when the case was under daily observation for some days before the photograph was taken or any treatment was begun.

2. The disappearance of the verrucæ planæ on the face and hands, and the improvement in the verrucæ vulgaris of the hands subsequent to the administration of large doses of an aperient medicine. This suggests that a chronic infection from the alimentary canal is an important etiological factor in some of these cases, and at the same time may afford an explanation of the variations in size and appearance just referred to.

In this connection it is of interest to note that the two classes of medicinal remedies that are recommended by most authorities for the treatment of verrucæ planæ are (*a*) magnesia, in small oft-repeated doses sufficient to induce an aperient action (Crocker), and (*b*) the internal administration of arsenic, a remedy which has been proved to possess a stimulating action on bone marrow (Stockman). It is conceivable that the manner of action of these two classes of sub-

* At this date the patient was shown at the Edin. Med. Chir. Soc., July, 1902.

stances is substantially the same, the aperient getting rid of a focus of septic absorption, and thus enabling the forces of nature, *e.g.*, the bone marrow, to reassert themselves; the arsenic inducing a greater functional activity of the bone marrow, which, there is good reason to believe, is the most important means of natural defence in the organism.

REVIEWS.

PHOTOTHÉRAPIE ET PHOTOBIOLOGIE.*

THE "Photothérapie et Photobiologie" of Leredde and Pautrier is the most complete contribution which has yet been published on this interesting and attractive subject. The volume extends to 257 pages, and is illustrated by a series of reproductions of photographs taken before and after treatment, and a number of drawings of the different types of lamps and other apparatus in use in connection with phototherapeutics. The whole subject is discussed in a philosophical, though at the same time in a thoroughly practical, manner by two observers who have had ample opportunity of judging of its value and limitations. Professor Niels Finsen, in a few introductory paragraphs to the book, goes so far as to declare that he not only considers the volume to be the most important recent work on the subject, but regards it as essential for all workers on phototherapeutics.

The first few chapters are concerned with the analysis of light by the spectrum, and the action of the various rays which compose it, especially on elementary forms of life such as bacteria. The researches of Duclaux, Arloing and Roux in this connection are specially described. A chapter is devoted to the action of light on plants, its necessity for the development of chlorophyl, and its influence on their structure and growth. The writers then go on to discuss its action on the lower animals, taking the frog as a type; and finally its influence on the human organism. The action of light on the skin is described in considerable detail. Its effect in provoking a more active circulation and an improved functional activity of the skin is discussed, as well as the production of pigmentation by it and its rôle as a process of defence against the harmful action of certain of the rays.

In this connection Eczema solare, Hydroa æstivale, Ephelides, Xeroderma pigmentosum and Pellagra are briefly described to illustrate the pathological effects of the actinic rays, and a reference is made to the baneful influence of these rays in the healing of the lesions in Variola.

The second part of the book deals with the practical application of light in the treatment of cutaneous affections. This is discussed at considerable length. The history of Finsen's classical work is described in detail. In discussing the various forms of apparatus and types of lamps which may be employed for the production of the actinic rays, they hold the opinion which is becoming more and

* *Photothérapie et Photobiologie*. By Leredde et Pautrier. (Paris: C. Naud. 1903. 4 frs.)

more prevalent that the deepest penetration and the most satisfactory results can be obtained by a lamp of the same type as Finsen's original lamp. They have also got excellent results from a Lortet-Genoud lamp with a continuous current; and to get sufficient penetration, with this lamp, they are in the habit of employing exposures of one hour instead of a quarter of an hour. The writers condemn the smaller lamps of the type of the Sophus-Bang lamp with iron electrodes, and find that, although they produce a greater proportion of ultra-violet rays than the larger lamps, practical experience has shown that their action is far too superficial to be of value. The naked-eye appearances produced by exposure of the skin to the lamps and the histological effects of the rays are carefully described. In discussing the treatment of Lupus vulgaris by the various recognised methods for combating the disease and comparing these methods, the advantage is certainly given to phototherapeutics. With regard to the superiority of light over X-rays, the writers give a somewhat guarded opinion, stating that at the present time with the present methods of employing the X-rays the treatment by light is "manifestly superior" to that by Röntgen rays. A reference is made to the most recent development on the subject—namely, the treatment by means of radium as proposed by Currie. The sulphate of radium mixed with chloride of barium is placed in caoutchouc bags and applied to the skin for various times. Rays are given from the radium, some of which are believed to be identical with the X-rays from a Crooke's tube, and these are said to have a beneficial effect on the skin. The subject is still *sub judice*. In the treatment of Lupus erythematosus by the Finsen lamp the writers have had singularly happy results. Out of twenty-three cases so treated thirteen have been cured, or almost so, and three were markedly improved. This form of treatment is also recommended by the authors for Rosacea, Sycosis, Tuberculides and Alopecia.

On the whole the volume will prove of undoubted value at the present time to all those who are actively working at the subject.

J. M. H. M.

THE COMBATING OF LUPUS VULGARIS.*

THIS short monograph, read at the International Congress on Tuberculosis at Berlin in 1902, and published in the form of a monograph, speaks more eloquently for the treatment of Lupus vulgaris by means of light-rays than anything which has yet appeared. It is illustrated by a series of twenty-four black and white plates, with two photographs on each, representing various patients before and after the light-treatment. These plates are preceded by a few convincing pages of letter-press, in which the following Table appears:—

Up to 31st December, 1901, Professor Finsen had treated 804 cases of Lupus vulgaris by means of the actinic rays; of these 681 were Danes, and 123 foreigners.

Up to the 1st October, 1901, the condition of things was as follows:—

I. Cured	412
(a) Free from relapses in from 2 to 6 years	124
(b) Time of observation less than 2 years	288

* *The Combating of Lupus Vulgaris*. By Niels R. Finsen. (Jena: Gustav Fischer. 1903. 2 marks.)

II. Almost cured (only insignificant traces of the disease persisting)	192
III. Under treatment	117
(a) Improved or partly cured	91
(b) Little influenced by treatment	26
IV. Incompletely cured	88
(a) Unsatisfactory results	16
(b) Dead (81) or suffering from other severer diseases	44
(c) "External circumstances"	28
	<hr/> Total 804

Leaving out of account Group IV. (b) and (c), there are left 787 cases; of these Group III. (b) and Group IV. (a), in all 42 cases or 6 per cent., may be regarded as unsatisfactory, while the remainder, 695 or 94 per cent., were greatly benefited if not entirely cured.

J. M. H. M.

CURRENT LITERATURE.

THE HISTOGENESIS OF SCALES AND CRUSTS. SABOURAUD. (*Journ. of Cut. Dis.*, February, 1908.)

R. SABOURAUD points out that the conception of the scale as a visible moulting of the skin due solely to abnormal over-production of the normally exfoliated layer of the epidermis is correct only for the scale of ichthyosis (a malformation), and the dry scales of simple pityriasis capitis. Neither the scale of steatoid pityriasis, of psoriasis, or of eczema, or tinea circinata, are formed by this mechanism alone, but by a combination of exfoliation and a degree of effusion only recognisable microscopically, and it is really a *scale-crust*. So, also, it is a prevalent idea amongst the uninstructed that the crust is formed from the effusion at the surface of the skin of serum finding its way from within the skin and concreting externally. The crust, however, is really constituted of coagulated serum, plus leucocytes, and almost always one or more layers of keratinised epidermis. Crusts may also contain pus, as in those terminating the evolution of the orificial follicular pustule (Impetigo of Bockhart), where the unruptured pustule dries up *in situ*.

Exocytosis Sabouraud defines as "a transmigration of leucocytes through the entire thickness of the epidermis, which are poured out upon the skin at its surface, or at the level of the horny layer." This phenomena is known to occur on the surface of mucous membranes, as, for instance, when a grain of dust traumatizes the conjunctiva, and is likewise extremely frequent in all superficial inflammations of the skin, even the most trivial, for example in pityriasis rosea, simple pityriasis of the scalp, and tinea circinata. In psoriasis, however, instead of issuing over a comparatively widespread area, the leucocytes concentrate at a single point to form a small superficial "abscess." The white globule is attracted, not only by parasites and their toxins, but by traumatism, even of a chemical nature. Are there other causes for this leucocytic exodus?

Exoserosis is the exudation through the epidermis, and at its surface, of a serous liquid coming from the derma. The serous afflux in the epidermis may produce a uniform oedema (spongiosis) or collect to form a vesicle, or it may collect just below the horny layer, and there concrete (exoserosis proper). The cause of this exudation is even less understood than leucocytic exodus.

These two synchronous processes of exocytosis and exoserosis contribute to form the greater number of crusts, which in the clinic are called scales. Trichophytosis furnishes a means of studying the general histological reactions of the skin, and Sabouraud gives figures displaying at one point a simple hyperkeratosis, at another a crust composed of a block of coagulated serum encased in corneous cells (exoserosis), and at another an exfoliated crust composed of horny layers, serum and dead leucocytes.

Sabouraud further demonstrates that the "steatoid" scale of pityriasis (seborrhœa corporis of Duhring) is not produced by the simple process of hyperkeratosis, but by the complex process which makes crusts.

The conclusion arrived at is that amongst the processes which go to make the scale of the usual histological type, *i.e.*, the *scale-crust*, the process of hyperkeratosis is a reactional phenomenon of the second order. The first two phenomena dominating its production are the *exhalation* at the surface of the skin of a serous "tide" and of a leucocytic "scum."

T. C. F.

DERMATITIS COCCIDIOIDES. (*Journ. of Cut. Dis., including Syphilis*, Vol. XXI., January, 1908.)

Drs. DOUGLAS W. MONTGOMERY, H. A. L. Ryfkogel and Howard Morrow publish a case read at the twenty-sixth annual meeting of the American Dermatological Association, 1902. The patient was a Swiss, aged 54 years, who had lived in the Western States of America since seven years old, but who had never resided in the San Joaquin Valley, whence the three patients previously seen by Montgomery had come. A gradual enlargement of the left hand and forearm was first noticed about seven years before coming under observation, and the following year the left leg and ankle began to enlarge. Four years later an eruption appeared on the chest, a year later on the left forearm and hand, and six months before the diagnosis was made on the neck and ears. A notable character, therefore, was the slow evolution of the eruption. On the chest and abdomen a papular eruption, centred by a confluent patch, had left a condition strikingly similar to the pigmented spots resulting from lichen planus. On the left forearm and back of left hand there was a discrete thick eruption of papules, pustules and nodules, which in its inception the patient said was like that on the chest. There was pustular folliculitis of the neck, dense enough on the right side to form a boggy mass. The condition of the swollen right ear reminded one of an acute dry eczema. There was hypertrophy of the skin and subcutaneous tissue of the left forearm, hand, both legs and left foot, and superficial elephantiasis of the left leg and foot, with papillary and corneous hypertrophy. The lower end of the left radius was separated from the shaft.

The general health was good, and the blood was normal, except for leucocytosis and eosinophilia.

Repeated antisyphilitic treatment, including increasing doses of potassium iodide

and parasiticide ointment, proved useless, but X-rays had a decided beneficial effect on the eruption on the forearm.

The patient got weak, had anorexia, nocturnal fever, rapid respirations and temporal pain. New circinate areas, with infiltrated and scaly borders, like a syphilide, formed on the sides of the neck, and the chest lesions ulcerated superficially. The neck and forearm lesions were pustular, exhaling a foetid odour. He died one year after the diagnosis was made, *i.e.*, after suffering from the eruption about eight years.

P.-M. examination revealed in the lungs extensive areas of broncho-pneumonia, and throughout the left lung and in upper lobe of right lung numerous bodies like miliary tubercles. The adrenals were enlarged and contained nodules, and the kidneys were the seat of cloudy swelling.

The lung and adrenal "tubercles" were composed of granulomatous tissue containing giant-cells and capsulated bodies, the latter often contained in giant-cells. The corium was found to be the seat of a diffuse cellular infiltration composed of plasma-, mast-, giant-cells and leucocytes, mostly polynuclear, extending to the subcutaneous tissue, marked around the vessels and appendages. Elastin destroyed and the fibrous bundles also in the denser infiltration. Vessels dilated. Giant-cells less numerous than in previous cases of *coccidioides*. Epithelial abscesses, so characteristic in blastomycosis, were rare, and the infiltration did not go on to abscess formation.

Groups of the organism in all stages of development were often found imbedded in loculi in dense cicatricial tissue.

Cultures of the organism were made after sterilising the skin, removing a nodule and maceration in sterile salt solution.

A marked difference between the organism found and the blastomycetes consists in the entirely different cycle of growth observed in the tissues and on culture media. In the tissues the organism is a sphere, 3.5 to 5 μ , surrounded by a clear capsule with a double contour, and in fresh specimens its outer wall is seen to be covered with spines. The small capsules have clear or granular contents, the larger ones are filled with endogenous circular, highly refractive spores, set free by rupture of the capsules. Every stage from spore to adult body existed. No micropyle is to be found in the capsule, and no budding or mycelial forms, and further the bodies are smaller and more numerous than blastomyces.

In a bouillon or agar hanging-drop inoculated with pus two or three mycelial threads spring from a *medium-sized capsule* and from that only; and branch and pursue a cycle like a mould fungus. No budding forms are seen. It grows on all the ordinary media, but not anaerobically, and liquefies gelatine slowly. It does not form gas on sugars. On dry solid media, as potato and carrot, it throws up fluffy white aërial hyphæ.

A considerable dose of these cultures was required to get positive results by intraperitoneal inoculation in guinea-pigs; but these proved fatal, with numerous scattered nodules in the peritoneal-wall and less constantly in various viscera, frequently with caseous adenopathy. Where pus formed, there numerous organisms were found. Smaller inoculation doses seemed only to give some local reactions.

[In connection with this paper we may refer to Gilchrist's communication published in the *British Medical Journal*, October 25, 1902, in which he brings forward evidence in favour of the view that the cases described as *protozoic dermatitis* are really another variety of *blastomycetic dermatitis*, only the

organism develops by sporulation instead of by budding. Orphitls demonstrated that the organism in his case was a mould-forming fungus, and Sanfelice showed that blastomyces could develop by sporulation.—REP.]

T. C. F.

REPORT OF A CASE OF FAVUS OF SCROTUM, CO-EXISTING WITH RINGWORM OF THE THIGH, GIVING IDENTICAL TRICHOPHYTON-LIKE CULTURES. (*Journ. of Cut. Dis., including Syphilis*, Vol. XXI., January, 1908.)

A. D. MEWBORN, after reviewing our knowledge of "*favus à lésions trichophytoïdes*" and researches of Bodin on the pleomorphism of the Microsporon of the horse, and the subsequent observations of Calvé and Malherbe on *trichophyton minimum*, and Truffi's experiments with pleomorphic growths in favus cultures, reports a case which he considers tends to still further break down the barriers between achorion and trichophyton.

A mulatto waiter developed a red scaly patch on the inner side of the left thigh in contact with the scrotum. The patch spread out on the thigh with an elevated, sharply defined, papulo-vesicular, polycyclical border, and similar patches, but simply red and scaly, appeared in the right inguinal region, on the abdomen, buttocks, and both axillæ. Simultaneously on the scrotum near its junction with the penis three groups of typical favus crusts formed. There is no history of their formation on any antecedent circinate eruption. The scales from the circinate patches disclosed thick septated as well as slender and branched mycelium of the trichophyton form, and endogenous spores (such as are sometimes seen in "*Eczema marginatum*." T. C. F.). The favus cups, on the other hand, showed irregular, dichotomized, interlocked, and clubbed segments with round and oval spores, as in favus of the scalp. Degenerated forms the author calls them.

Cultures were made on glucose agar. Pure cultures from the scaly patches became crateriform, whilst the growths from the favus cups, which the author was lucky enough to get pure at the first sowings, did not assume the waxy or cerebriform aspect, typical of favus, but resembled more the acuminate or button form of the trichophyton endothrix. On beer wort agar, the fungus from the scaly patches presented a growth with a very convoluted central portion and a fern-leaf edge. Drop cultures in 2 per cent. glucose bouillon showed the same form of reproduction by chlamydospores from both sources, and in both grape-formation was observed, but in the favus culture the spores were attached directly to the stem, whilst in the ringworm culture they were attacked by sterigmata. Inoculation on the author's arm and on mice with the favus cultures failed, but the "ringworm" culture was successfully inoculated on a rabbit's back and gave rise to favus cups, and cultures from these cups on glucose agar gave typical crateriform patterns.

The author concludes that the same trichophyton (*a megalosporon ectothrix of probable animal origin*) on the same patient, but in different parts of the body, where the conditions of soil were different, produced two clinically distinct diseases—favus and ringworm. In this connection he quotes Bukovsky's conclusion that "the more indifferent the skin is to the fungi (Achorion), the more likely it is to show the favus cup. The stronger the reaction of the skin against the mycelium, the less the tendency to scutulum building."

T. C. F.

OF PURPURA, AND ESPECIALLY OF THAT FORM WHICH OCCURS IN SARCOMA, LYMPHADENOMA, AND TUBERCLE. W. P. HERRINGHAM, M.D. (*St. Bartholomew's Hospital Reports*, Vol. XXXVIII., 1902, p. 117.)

PURPURA is taken to mean the occurrence of hæmorrhages from minute blood-vessels, which are at once widespread and independent of any obvious local disease. It is a symptom rather than a disease; yet most likely there is always some disease of the vessels concerned, and sometimes of the blood itself.

Cases of Purpura may be classified into:—

(1.) Idiopathic, comprising—Purpura simplex (where the symptoms are slight and confined to the skin), Henoch's Purpura, where in addition there are such gastro-intestinal symptoms as pain, vomiting and diarrhoea, and other cases the causation of which we do not know.

(2.) Cases due to obstruction to the circulation, as in heart-disease, or the congestion arising from convulsions, coughing fits, &c.

(3.) Cases due to nervous influence upon the blood-vessels, as in tabes dorsalis, and perhaps hysteria.

(4.) Cases connected with rheumatism. These exhibit various grades from erythema to purpura.

(5.) Cases due to absorption of poison from without (*e.g.*, snake-bite, iodine, phosphorus).

(6.) Auto-intoxication, as in nephritis or cirrhosis of the liver.

(7.) Acute specific diseases (small-pox, typhoid).

(8.) Pernicious anæmia, and leucocythæmia.

(9.) Scurvy.

(10.) Septicæmia. Purpura is common in cardiac septicæmia (infective endocarditis), but less common in septicæmia without heart-disease.

Three examples of this latter condition are given.

Purpura in Septicæmia (other than Infective Endocarditis).

Male, aged 20: June 23, 1901.—Bleeding from gums; June 24, felt ill, headache, sore throat, general Purpura. On admission, June 24, hæmorrhages also around gums and in right tonsil, hæmaturia developed. Fever 101°–103°. Died June 27.

P.M.—Hæmorrhage in almost every organ of body. Glands enlarged but not hæmorrhagic.

Bacteriology.—Streptococci and a large anaërobic bacillus.

Female, aged 48.—Four months, weakness, wasting, anorexia. Sixteen days painful lumps in arm. Admitted June 30, 1896. Large bruise right elbow, small bruises on legs, on abdomen “a thick, punctate, papular, erythematous rash, mostly petechial.” July 4, pain and swelling about extensor tendons left wrist; inflamed patch near right ankle. July 6, hæmorrhage into conjunctiva, and anterior chamber of right eye.

Blood.—Red, 1,350,000; white, 1,000; hgb. 23 per cent. Fever, 101°–104°. Died July 7.

P.M.—Nothing but hæmorrhages into lungs, and into bladder, and into the swellings noted.

Bacteriology.—Streptococci and diplococci found in cultures from spleen.

Female, aged 8.—Whooping-cough some months before. Three days anorexia, blood noticed on teeth. Admitted September 12, 1900. Rickety child, very pale, drowsy, general tenderness, bleeding from nose and from gums, small purpuric rash. September 14, blood in vomit and stools.

Blood.—Red, 2,000,000; white, 28,800.

Culture.—Pure colonies of streptococci.

Temperature.—104° on admission, afterwards normal.

Died. *P.M.*—Hæmorrhages in lungs, liver, and kidneys. Pelves of kidneys and ureters full of foul grey stuff, probably decomposing phosphates.

The purpura in these cases of septicæmia is probably due to damage of the vascular walls wrought by minute septic emboli.

(11.) Certain very rare cases of purpura in the course of malignant disease, that is to say, cases of copious hæmorrhage, often into other parts besides the skin, occurring at an early stage of the disease, and differing therefore from the more common cases of scanty petechiæ occurring in the later and cachectic stage. This form of purpura has been observed only in sarcoma and lymphadenoma, not in carcinoma, and generally in cases where the growths become widely disseminated.

Purpura Hæmorrhagica and Erythema Sarcoma.

Male, aged 86, ill four weeks, with pain in head and stomach, and later a rash, ulceration of mouth and swellings of divers parts.

On admission (Nov. 19, 1900), circular spots of erythema on face, trunk and arms, hæmorrhagic on legs. Ulceration, with hæmorrhage, of mouth and uvula, enlarged and painful cervical glands; swelling of face, right arm and both legs.

During the next few days redness and swelling (arthritis?) of left elbow developed. The rash became more hæmorrhagic, but finally disappeared. The blood was normal. Temperature slightly raised 101° at first, afterwards normal.

There followed further "swellings" on left wrist and right forearm; enlargement of other glands, fresh purpura, bloody diarrhoea, hæmatemesis. The patient became anæmic, tumours developed under the skin, and in the splenic region. Died February 18.

P.M.—Round-celled sarcoma of mesenteric glands matting the peritoneal tissues together (=tumour in splenic region). New growth in cervical, axillary and inguinal glands, in posterior mediastinum, and round abdominal aorta; in lungs, pleuræ, and kidneys. Ulcer of stomach.

Obstinate Purpura Hæmorrhagica. Sarcomatous Tumours found Post-mortem. (Quoted from Sale, *St. Bartholomew's Hospital Journal*.)

Male, aged 56. For nearly four months attacks of bleeding from nose and gums. Vomittings, but not of blood: purpura of legs, tendency to bruise. Loss of weight. No defect of diet. No family history of hæmophilia. Admitted February 27, 1902. Bleedings from nose and gums, which resisted all treatment and gradually became continuous. Slight purpura and marks like old bruises on legs, which cleared up. Gradually got paler and weaker, and died May 8, six months after onset of first symptoms.

P.M.—Numerous growths (round-celled sarcoma) in bones of skull; from one of these, in the left ethmoidal sinus, the nasal hæmorrhage had come. No growth in the gums. Fatty heart and kidneys, some sub-pericardial hæmorrhages.

Purpura in Lymphadenoma.

Male, aged 85. Short breath and pain in ankles for a year. "Rheumatic fever" eight months ago, ailing since.

Admitted April 11, 1901, with fever, enlarged spleen, blotches on arm, hæmorrhages from mouth, nose and kidneys.

Blood.—Red, 2,280,000; white, 11,000; hgb. 46 per cent. Cultures sterile.

May 11-17, doubtful attack of rheumatic fever. June 29, large glands in neck and axillæ; recurrent febrile attacks. No hæmorrhage into skin or elsewhere from May till July 21, when epistaxis occurred. Repeated febrile attacks; died September 30.

P.M.—Lymphadenomatous growths (containing tubercle also) in spleen, liver, tracheal, bronchial, and abdominal glands.

The author refers to similar cases of purpura hæmorrhagica occurring in connection with sarcoma or lymphosarcoma from Fagge, Marshall, Roth, Harris, Nasow, Martin and Hamilton.

He draws attention to the fact that in none of the cases quoted by him did the hæmorrhage take place solely into pre-existing new growths; they were not, therefore, cases of pure multiple hæmorrhagic sarcoma. Though some authors think, even so, that there really is a sarcomatous deposit at the site of each hæmorrhage, the fact that such hæmorrhages may clear up altogether, and also the fact that such growth has been looked for, microscopically, in vain, disproves their view. Neither can the hæmorrhage be due simply to anæmia, for some of these patients were not anæmic.

The author suggests that sarcoma cells, which (unlike carcinoma cells) are distributed by the blood-stream, collect in the minuter vessels and sometimes find a permanent foothold, so as to form a growth, but sometimes only maintain their position long enough to cause some lesion of the vascular wall sufficient to allow of an hæmorrhage. It is possible also that, like septicæmic emboli, the sarcoma cells may have some poisonous quality, and that the recurrent febrile attacks observed in such cases may be thereby explained.

II.—A Still Rarer Case of Purpura in Disseminated Tuberculosis.

Male, aged 27, ailing three weeks, swelling of neck nine days, slight enlargement of gland in right neck for some years, purpura two days.

Admitted March 23, 1897; enlarged glands in neck and left axilla; Purpura hæmorrhagica of mouth and skin, hæmaturia, hectic fever.

Blood.—Red, 2,556,000; white, 6,000; hgb. 37 per cent.

Cultures negative.

By April improvement; no sign of disease in chest.

Early in May became delirious; died May 18.

P.M.—Acute tubercular adenitis (deep cervical glands much enlarged, some enlargement also of the axillary, tracheal, bronchial, portal, and a few of the mesenteric glands); miliary tubercle of lungs, liver, spleen, kidneys; tubercular meningitis.

One somewhat similar case of purpura in the course of phthisis, terminating with tubercular meningitis, is quoted from Charcot.

The author suggests that, as the early hæmoptysis and early slight hæmaturia of phthisis is ascribed to irritation from the deposit of the tubercle bacillus in the

lungs and kidneys, so Purpura hæmorrhagica may be caused by its deposit elsewhere.

J. A. ORMEROD.

DERMATITIS TOXICA, DUE TO RHUS VERNICIFERA. A. BURACZYŃSKI. (*Wien. klin. Rundschau*, p. 955, No. 50.)

DERMATITIS produced by two other varieties of Rhus—Rhus toxicodendron and Rhus venenata—is well known in North America, where these plants are fairly common. Handling of these plants produces in predisposed individuals vesicles, pustules, erysipelatous reddening and swelling of the skin, with acute pain, and in some cases disturbance of the kidney secretion. The active poison has been shown by Pfaff to be toxicodendrol, of which $\frac{1}{1000}$ mg. in two drops of olive-oil produced localised œdema and vesiculation.

But cases of poisoning by Rhus vernicifera appear to be very rare, at any rate in Europe. The plant grows in Japan, and the stem and under surface of the leaves are covered with hairs which contain the milky juice, which, when dried, constitutes the dark-coloured Japanese varnish.

The case now recorded is that of a gardener, aged 68, who was employed at the Vienna Botanical Garden. Four days before he came to hospital he had been replanting some plants of Rhus vernicifera. On that day he had complained of redness, swelling and itching of the face and hands. When seen the face was covered with large and small red plaques, the skin and cellular tissue markedly infiltrated, the eyelids swollen, and the alæ of the nose and cheeks œdematous. The redness extended forwards on to the chest. The hands and forearms were also red, and to a slighter extent the genitals. The temperature was raised over the affected areas. No fever. Patient complained continually of acute pain, which was increased by pressure.

Thus those parts which were exposed suffered, the genitals having been probably infected by the hands, and the toxic hairs of the plant had adhered to the exposed perspiring portions of the skin, and to the openings of the sweat-glands.

The patient improved with the application of a dusting-powder, and after desquamation was cured in a fortnight.

J. L. BUNCE.

THREE CASES OF ACNEIFORM TUBERCULIDE. S. EHRMANN. (*Wien. klin. Rundschau*, November 30th, 1902.)

IN one of these cases the tuberculide was associated with typical Lupus erythematoses. The tuberculides consisted of bright red nodules of the size of hemp-seeds, distributed over the knees, elbows, ankles, and wrists. Within a short time they became flat in the centre, changed to a blue and then to a yellow colour, with the formation of blackish adherent crusts, which separated later on, leaving a covered depression of corresponding size.

The scar, which was at first bluish, became white, and the lightly pigmented or hyperæmic areola disappeared. At times a number of these nodules fused to form plaques, like those of lupus pernio. Histologically the nodule was shown to be formed of inflammatory infiltration, with necrosis of the central and superficial layers. The base of the nodule showed constantly typical phlebitis and peri-

phlebitis, and even thrombosis. Tubercle bacilli were only found once; indeed, the structure of the lesions did not appear to correspond with tuberculosis. But if the lesions were not themselves tubercular, they were certainly associated to a certain extent with tuberculosis, for on the one hand they occurred in patients who suffered with tubercular lesions of other organs, and on the other hand in patients who had a strong hereditary predisposition to tuberculosis.

J. L. BUNCH.

ON LIGHT THERAPEUTICS. - BIE. (Report of the Twentieth Medical Congress in Wiesbaden.) (*Wien. klin. Rundschau*, No. 87, p. 723.)

THE views of Bouchard, Widmark, and Finsen are upheld as regards the capabilities of the chemical rays, but not red, yellow, or green rays, to produce inflammation of the skin. Blue and violet rays can penetrate deeply into the skin only when it has been made bloodless. Ultraviolet rays can under no circumstances penetrate deeper than the superficial layer of the skin, but here they may give rise to dilatation of the vessels which can persist for five or six months.

Bie summarises his views as follows:—(1) Finsen's treatment of small-pox with red light depends on the exclusion of the irritating action of chemical light-rays, and thus the prevention of pus formation in the vesicles, secondary fever, and scars. (2) The red-light treatment of other exanthemata has not as yet been thoroughly tested. (3) The universal light-treatment of the future will undoubtedly be sun-baths, or exposure to arc-lamps of 150–200 ampères. At the present moment, however, too little is known of the general working of light to strictly define any very definite indications. (4) The single method of light-treatment whose success is firmly established is Finsen's method of treating skin-diseases with concentrated chemical rays. The excellent cosmetic results are to be ascribed to the fact that the method of treatment is essentially preservative. Nothing is destroyed, no contraction of the tissue results, the scars are smooth and white. Inasmuch as the method is preservative, surrounding healthy skin can be exposed to the rays as well as the diseased area, and thus the danger of recurrence is diminished. The treatment is free from pain, and the results are excellent. Of 640 patients, only 1·7 per cent. had to give up treatment because of unfavourable results; 85 per cent. showed absolutely favourable results; and only in 15 per cent. was the improvement so slow that the treatment had to be described as less successful.

J. L. BUNCH.

CLINICAL OBSERVATIONS ON TUBERCULOSIS OF THE SKIN.
NEUMANN. (*Wien. klin. Rundschau*, p. 1, January 4th, 1908.)

ALTHOUGH the direct transmission of tuberculosis from man to man can and does occur, the experimental transmission of lupus from man to man has so far not been successful. Nevertheless the presence of tubercle bacilli has been demonstrated in lupus nodules. Koch has cultivated tubercle bacilli in pure growths from lupus, and has induced tuberculosis in animals by inoculation of these cultures; moreover, the transplantation of lupus tissue in the peritoneal cavities of rabbits and guinea-pigs produces generalised tuberculosis in these animals. The direct inoculation of tuberculosis in man is perhaps best seen in ritual circumcision. Thus in three months at Rjeshiza one tuberculous operator

has infected numerous children, and of these children seven have since died. Neumann has himself seen four children similarly inoculated in one town during one year. Of these four children one died of apparent gastro-enteritis; one died of tuberculosis of the lungs; one remained healthy; and of the fourth no information could be obtained. Children so infected are a danger to themselves, inasmuch as other regions of the body, especially if they suffer from any simple dermatitis, may become inoculated from the circumcision scar, or from the infected glands, and they are also a source of danger to their nurses and to other children, causing either lupus, tuberculosis verrucosa cutis, or tuberculosis miliaris ulcerosa.

Direct inoculation of tubercle bacilli can also take place by contact with tubercular mucous membranes, whether of the vulva, anus, or lips, and Neumann is of opinion that tuberculosis of the lungs is not *per se* the most dangerous form of tuberculosis to individuals other than the patient. Indirect infection is, of course, well known, but none the less difficult to guard against.

J. L. BUNCH.

AN ERYSIPELAS-LIKE DERMATITIS DUE TO FRÄNKEL'S PNEUMOCOCCUS. FORSSMAN. (*Hygiea. Medicinsk och Farmaceutisk Månadskrift.*, Stockholm, 1900. Reprint.)

IN the case of a servant-maid, aged 20, who was admitted to the Medical Clinic at Lund with the diagnosis of Tuberculosis pulm., nephritis chron. parenchymatosa, and degen. amyl. renum on March 12th, 1897, and who died on the 27th of the following month, Forssman was able to cultivate the pneumococcus of Fränkel from fluid obtained from the subcutaneous tissues of the left leg. In this position, in addition to the œdema, there was some redness of an erysipelas-like aspect. At the necropsy the infiltration of this erysipelatous area was distinct from the surrounding ordinary œdema, and had a somewhat well-defined border. There had also been small bullæ with fairly clear contents (some were present at necropsy, with numerous very small livid spots). The author found only one reference to anything similar to the above case, viz., in "Erichsen's Surgery," where it is described as œdematous erysipelas (*see Ninth Ed., Vol. II., p. 952*).

GEORGE PERNET.

[Forssman's case is briefly referred to in Rasch's "Hudens Sygdomme og deres Behandling," Part I., Copenhagen, 1902, p. 139.—G. P.]

THE X-RAYS IN THE TREATMENT OF MALIGNANT GROWTHS. J. RUDIS-JICINSKY. (*New York Med. Journ.*, August. 30th, p. 870.)

IN healthy tissue, the author states, irritation of the peripheral extremities of the sensory nerves causes a paralysis of the vasomotor nerves of the vascular area affected, spasmodic contraction of the arterioles and capillaries follows, and proper nutrition of the cells is impaired. There may be relaxation, but inflammatory phenomena are manifested, not only at the focus of irritation, but perhaps over a large continuous surface, a wide vascular area. With these changes, which are directly dependent upon disturbances of the circulation, occur changes in the parenchyma cells and connective tissue cells of the affected region. Since such dermatitis, or

even necrobiosis, may result in normal tissue as a result of X-ray application, the same, or more marked effects, will probably be brought about by the same cause in injured or diseased tissues which are more susceptible to its action. Thus the destruction of malignant growths can be effected by means of the application of the Röntgen Rays. The author, however, recommends the use of the knife as an adjuvant to the light-treatment. He first "clears the field of infection with the rays," then excises the growth, then applies the rays, and once again to preclude recurrence and get a better scar. Such precautions are wise, because the patient may seem to have improved from the cancer by the ray-treatment, but may die from sepsis produced by the rapidly disintegrating tumour. J. L. BUNCH.

PILGRIM'S ULCERS (CHRONIC ULCERATION OF THE SOLE OF THE FOOT). FRANK MILTON. (*Records of the Egyptian Government School of Medicine*, 1901, p. 183.)

A FAIR number of such cases occur in the practice of the Kasr-el-Aîny Hospital, Cairo. They are of great clinical interest, being quite intractable and resistant to any form of treatment. They are probably due to some special micro-organism or parasite, which Symmers has not yet been able to isolate, his investigations having up to the present remained negative. The ages of the patients vary from boyhood to middle age, and the ulcers have always been of long standing. The ulcer is situated over the heel usually, but it may occur in any part of the sole of the foot. It is more often single. The shape is irregular, more or less circular or oval, with hard, heaped-up edges. It is essentially superficial, but in an exceptional case it had burrowed in one part and attacked the metatarsus. The surface is covered by finely granular bluish granulations, discharging a small quantity of thin watery pus. They are apparently quite painless. The foot attacked is generally distorted and scarred. One case was under observation on and off for four years, and there was practically no alteration in size or position during that time, no fresh ulcers occurring. The foot is often deformed in other ways, as by absence or loss of toes, or its shape is defective, and the cuticular sensation is sometimes impaired. The local signs, indeed, all point to the disease being leprous, but as yet Milton has never seen these particular ulcers occurring in evident lepers. He has, moreover, never seen any other evidence of leprosy in the possessors of these sores, and the ulcers of the sole in lepers differ materially from those under consideration, especially as regards the tendency of the leprous ulcers to extend deeply and to cause caries of the bone.

If the Pilgrim's ulcers be removed by excision the resulting granulating surface gradually takes on its former characters whatever dressings are applied. Skin grafts do not take well, and if they do, break down and disappear. The only thing which leads to some improvement is zinc plates shaped to the ulcer, but it is the rule for the ulcers, after healing up to a certain point, to recommence slowly to spread and reach their original proportions. GEORGE PERNET.

THE ÆTIOLOGY OF ALOPECIA AREATA. TRÉMOLIÈRES. (*La Presse Médicale*, June 14, 1902.)

THE author discusses the ætiology of Alopecia areata with special reference to the dental theory of Jacquet. The question of ætiology has been the subject of

much controversy, and dermatologists are divided into contagionists and non-contagionists. The subject is important socially, as well as being of scientific interest, since it concerns public hygiene.

Jacquet holds that the alopecia is not a specific disease but only a symptom of a complex morbid condition. This condition concerns a dissemination in cutaneous and vascular tone. He mentions "agenesie pileaire" as a predisposing cause, creating a vulnerability of the hairy system. Jacquet has also found deficient elimination of salts in the urine. Jacquet has noticed the frequent co-existence of dental lesions with alopecia, and has endeavoured to establish a connection between them. Alopecia often follows subjective symptoms in the region of the trigeminal—inflammation and neuralgia. Alopecia of the beard has been noticed three months after severe neuralgia of the same side; alopecia areata disseminata after bilateral dental pain; a patch of fronto-temporal alopecia has followed three weeks after neuralgia of the same side of the head and face, &c. The interval between the neuralgia and the alopecia varied from three weeks to three months. Out of 200 cases, Jacquet established this connection in 27 cases; in others the neuralgia was perhaps slight or ignored. When neuralgia was bilateral, the alopecia was bilateral also, and in some cases each attack of neuralgia was followed by a relapse of alopecia. Besides neuralgia there are vasomotor, thermal, inflammatory and trophic phenomena, more or less marked, which form the foundation of the sensitive elements. There may be coryza or epistaxis. On the side of the alopecia there is often some flushing of the cheek or ear; sometimes sub-maxillary adenopathy.

This group of symptoms is connected with the region of the trigeminal nerve, and in this region the origin of irritation must be sought. The eyes and nasal fossæ do not appear to be affected; but the dental apparatus, owing to the frequent lesions by which the teeth may be affected, seems to be the point of origin of the irritation. The frequency of alopecia at different ages supports the dental theory. In 278 cases of alopecia 185 cases occurred in the 25 years corresponding to the periods of eruption of teeth; while in the interval, between 15 and 19 years of age, there was absence of alopecia.

The maxillary, cervical, and supra-auricular regions are under the same nervous influence (second and third cervical nerves), although the classic treatises, by an artificial division, make them independent. Also these regions are relatively poor in nerves. It remains to describe the course which unites the dental point of departure, rich in nerves, to the point of arrival with poor innervation. The stimulus passes from the dental nerves to the gasserian ganglion and from this to medullary nucleus. Then it follows the long inferior root of the trigeminal nerve containing sensory nerves, and also the first pair of cervical nerves.

Jacquet concludes that alopecia areata is a trophic affection, a frequent cause of which is irritation of the buccal branches of the trigeminal nerve and reflected to the point of cutaneous innervation corresponding to the point of irritation. Removal or treatment of a diseased tooth have caused arrest of the alopecia. Alopecia may be caused by other sources of irritation than those of dental origin; the chief of these are auricular, pharyngeal, gastro-intestinal, pulmonary and traumatic. Besides alopecia of reflex origin it appears necessary to admit the existence of a central origin. Alopecia is a

symptom which realises the unity of pathogeny under ætiological multiplicity. (Jacquet. *Bull. Soc. Derm.*, March, 1902.)

C. F. MARSHALL.

INTRA - VENOUS INJECTIONS OF MERCURY IN SYPHILIS.
BOUZITAT. (*Thèse de Paris*, July, 1902.)

THE author gives an account of this method of treatment.

Technique.—The best syringe is of glass with a platino-iridium needle. The salt of mercury used must be soluble; perchloride of mercury, 1 in 1,000, has been used by some; others prefer cyanide, 1 per cent. One of the veins in the bend of the elbow is usually chosen and the needle is inserted at an angle of about 45°. Before making the injection the elastic band used to dilate the veins must be removed. If performed carefully and aseptically no reaction occurs at the puncture. The author uses 1 ccm. of cyanide, 1 per cent. repeated every other day. In severe cases, such as cerebral gumma, myelitis, &c., injections should be made every day. If salivation or diarrhoea occur, the injections must be stopped for a time. If perchloride is used the daily dose should not exceed 5 milligrammes.

Advantages and disadvantages.—The advantages are: (1) Simple technique; (2) painlessness; (3) absence of induration; (4) rapidity of action; (5) certainty in effect; (6) small dose required; (7) mercurialism is less liable to occur and the mercury is eliminated more rapidly than in other methods; (8) the exact dose of mercury is known; (9) injections can be repeated more often than hypodermic or intra-muscular injections.

The disadvantage is said to be the danger of thrombosis or embolism, but this is theoretical. It was thought that the perchloride, if used, might cause coagulation of the blood in the circulation as it does in blood removed from the body, but the quantity injected is so small compared with the mass of blood that such an event is hardly possible.

The only contra-indication is in cases where the veins are not sufficiently prominent, as in some women and fat subjects. The injections may be used in all forms of syphilis and at all periods; but they are most useful in grave cases which require energetic medication, such as phagedenic chancre, severe ulceration, early syphilis of the nervous system, &c. In tertiary syphilis, according to the author, the best results are obtained. Finally the author remarks that it is possible that intra-venous injections may be successful in general paralysis, tabes, aneurism and other parasymphilitic affections, which possibly resist certain forms of treatment, but not others.

C. F. MARSHALL.

ELECTROLYTIC TREATMENT OF XANTHELASMA. PANSIER. (*Arch. d'Electr. Médicale*, July, 1902.)

THE author points out that in the electrolytic treatment of xanthelasma the negative pole should be used. This results in a soft non-retractile scar. Steel needles may be used without fear of tattooing the skin. The positive pole is connected with a sponge placed on the cheek. Currents of 6 to 10 milliampères are used for about two minutes. Pansier recommends the simultaneous use of several needles, to reduce the length of sittings, as the method is not painless. The patch should be completely transfixed by the needle. Pain may be diminished by rubbing

the eyelid with menthol and hydrate of chloral aa 8 grammes in 6 grammes of lanoline. The number of sittings varies with the method employed. If several needles are used close together a considerable result is obtained at one sitting. Generally about fifteen days afterwards a second application is enough. The same spot should not be treated for twelve or fifteen days.

C. F. MARSHALL.

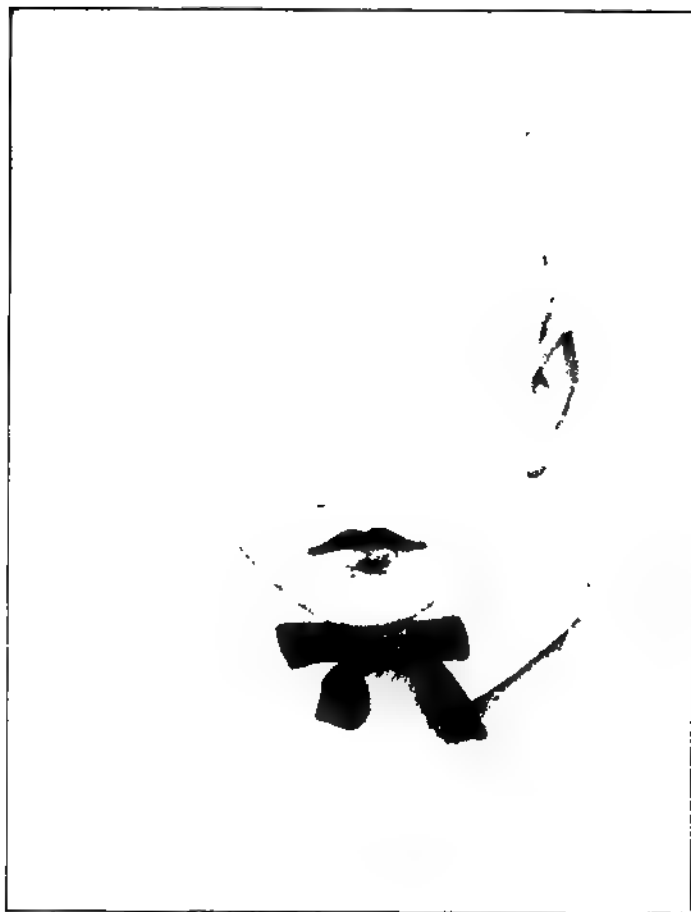
X-RAY DERMATOSIS. PRINCE. (*Philadel. Med. Journ.*, August 9th, 1902.)

THE author describes a case of X-ray dermatosis which occurred in his own person. The left hand was affected after using tubes in which the vacuum had been reduced by repeated use. The hand was red and somewhat swollen from the wrist to the finger tips. There was no loss of hair or desquamation. The condition subsided spontaneously, but recurred five months later. A third attack occurred in 1898 and continued to the present time. There was brittleness of the nails and desquamation. The swelling subsided in the hand, but remained on the dorsum of the fingers. The redness is most marked in warm weather. Small warty growths form on the fingers and the roots of the nails are fibrous. The hair is lost on the outer half of each proximal phalanx. The senses of touch and pain are impaired in direct proportion to the intensity of the dermatitis. Heat and cold sensations are not altered. The condition appears to be a disturbance of nutrition of the skin associated with chronic fibrosis in the derma.

As regards treatment Lassar's paste caused only temporary relief. Tar, salicylic acid and ichthyol gave no benefit. The best application was ol. morrhue, zinc oxide and lanoline.

C. F. MARSHALL.

PLATE I.



DR. MACLEOD'S CASE OF GRANULOSIS RUBRA NASI

PLATE II.

DR MACLEOD'S CASE OF GRANULOSIS RUBRA NASI

THE BRITISH JOURNAL OF DERMATOLOGY.

JUNE, 1903.

A CASE OF "GRANULOSIS RUBRA NASI" (JADASSOHN).

By J. M. H. MACLEOD, M.D., M.R.C.P.,

Physician to the Skin Department, Victoria Hospital for Children, Assistant in the Dermatological Department, Charing Cross Hospital, and Lecturer on Skin Diseases, London School of Tropical Medicine.

IN 1901, in the *Archiv für Dermatologie und Syphilis*, Jadassohn described a number of cases of a peculiar disease of the skin of the nose in children, to which he gave the name of "Granulosis rubra nasi." The essential feature of this affection was a localised erythematous patch on the tip of the nose, dotted over with numerous reddish brown macules and micro-papules, and moist and glistening with beads of perspiration, and associated with hyperidrosis of the hands. He described seven such cases, and these so closely resembled one another as to leave no doubt that they belonged to the same group. A somewhat similar case was reported in the previous year by Luithlen, and cases have been described since then by Herrmann and Walther Pick. As none of the reports of these cases was accompanied by drawings or photographs, and although the descriptions of these writers were accurate and sometimes vivid, speaking for myself, they recalled nothing I had seen before, and I was unable to picture to myself exactly the condition they were describing.

Recently a boy was brought up for advice to the Skin Department of the Victoria Hospital for Children, suffering from an affection of the skin of the nose which at once suggested the disease described

by Jadassohn, and on re-reading his paper no doubt was left as to its identity.

As I am not aware of this skin-affection having been previously recognised as an entity in this country, I thought that the case deserved a more extended and detailed report than it was possible for it to receive in the "Transactions of the Dermatological Society of London," where the patient was shown at the March meeting.* Doubtless cases of this type have been from time to time seen, but have probably been passed over as eczema, rosacea, hidrocystoma,† and possibly Lupus vulgaris, but, on looking over the literature, I can find no adequate account of the affection till Jadassohn described his case, and gave it a name.

DESCRIPTION OF THE CASE.

Richard W., a delicate-looking, nervous boy, aged 6 years, was brought to the Victoria Hospital for Children on the 18th February, 1903, suffering from a persistent red patch on the nose which was dotted over with small beads of perspiration and reddish brown papules varying in size from a pin's point to a pin's head.

Family History.—The mother of the child is a strong healthy woman. The father is a nervous man and suffers from a weak peripheral circulation. His hands are usually more or less cyanosed, and, according to his statement, "go dead at times." He does not suffer from hyperidrosis, nor is he subject to any form of skin-disease.

The patient is the second youngest of four, the others all being healthy.

Past Personal History.—The patient has had the usual complaints of childhood, such as measles and scarlet fever, but no previous skin-affection. He has always been a nervous boy and more delicate than the other children, but he has had no definite nervous disease such

* *Brit. Journ. of Dermat.*, 1903, XV., p. 131.

† At the meeting of the Society Dr. J. J. Pringle stated that he had had two cases under his care similar to the one exhibited. Those cases occurred in a brother and sister, and he had recognised their peculiarity, and had labelled them provisionally as "Hidrocystoma."

as chorea. The glands in his neck have not been swollen. Six months ago he had his tonsils cut at St. Thomas's Hospital.

The lesion on the nose began when he was six months old. At that time the mother noticed that his nose was always red near the tip, and that the red area was moist with perspiration. She also noted that his hands were moist. According to the statement of the mother the affection of the nose has persisted with little or no marked change since then. It is said to be more vivid in summer, in the hot weather, than in winter, and the redness and perspiration naturally increase after exertion. Emotion is said to have no effect on the condition. Three months ago the upper lip became involved, and beads of perspiration appeared there, but only recently have inflammatory lesions developed. This is a significant fact, suggesting that the perspiration precedes the formation of the inflammatory papules.

The boy has been under treatment, on and off, for a number of years. Various local applications have been tried, but all of no avail. So persistent and chronic did the condition become that the mother says that she was told at St. Thomas's Hospital that the nose would have to be scraped.

Present Condition.—On presenting himself at the hospital, the boy appeared to be delicate and nervous. He had a fair complexion and brown eyes. The condition of his nose was remarked the moment he entered the room. A glance at Plate I., which is the reproduction of a photograph of a coloured drawing by Miss Mabel Green, shows the extent of the area involved. The lesion consisted of a hyperæmic patch extending from the tip of the nose, at the anterior aspect of the column between the nares up to the bridge, and spreading out latterly as far as the middle of the alæ nasi. The patch was symmetrical, and involved an area as if a triangular piece of plaster had been cut to the size and bent over the ridge of the nose. The patch was not definitely demarcated, but the hyperæmia faded gradually into the neighbouring skin. Over the whole area there were numerous punctate beads of perspiration, which gave the patch a damp glistening appearance. The area of excessive sweating is well shown in Plate II., where the moist patch is covered over with finely powdered charcoal. The charcoal was puffed over the face, and then brushed off. It adhered to the moist area, mapping it out clearly from the surround-

ing skin.* On applying red litmus paper to the nose, the paper became dotted over with blue specks, showing that the perspiration was distinctly alkaline in reaction, instead of being acid as it usually is. But the most permanent feature of the patch was the presence of a large number of discrete macules and micro-papules. These were brownish red in tinge, rounded or acuminate in shape, and varied in size from a pin's point to a pin's head. They completely disappeared on pressure with a glass slide or diascopé, leaving no brown staining such as is left by a nodule of *Lupus vulgaris*, or a papular syphilide. These small papules were irregularly distributed, and showed no tendency to become confluent. The patch was scarcely, if at all, infiltrated, but the presence of the papules on its surface gave it a granular feeling, which suggested the name "Granulosis" to Jadassohn. The sweat-beads were independent of the papules, but there were a few small translucent papules, which suggested underlying vesicles. The papules did not present pores at their apices, nor were they umbilicate.

The appearance of the patch varied only slightly from time to time, and that only in the depths of the hyperæmia, for in its quiescent stages this, to a large extent, disappeared, leaving the skin between the papules almost normal in tint. In association with the papules there were no crusts, depressed scars or telangiectases. Though a hyperidrosis was also present on the upper lip, and beads of perspiration were noticeable, only a few papules were detected, but the lips were both slightly cyanosed. The subjective symptoms in connection with the lesion were slight, and consisted of itching of a mild degree, chiefly affecting the upper lip; this caused the boy to rub the lip, and occasionally the nose, which increased the inflammatory disturbance. The hands were also slightly cyanosed, and were moist from hyperidrosis.

An examination of the naso-pharynx with a view of detecting adenoids, and of the pupil reactions to determine whether the sympathetic was acting normally, was followed by negative results.

* This simple device, suggested to me by Dr. Purves Stewart, is useful not only to graphically demonstrate areas of hyperidrosis, but also areas in which sweating is absent, for if the charcoal be gently blown off it will even adhere to areas where the sweat-glands are secreting normally.

Histology.—A biopsy was made, and a very small piece of tissue excised from the left side of the nose. Owing to the situation of the lesions and the thinness of the skin there, it was difficult to excise sufficient tissue to give conclusive results without leaving a scar. Jadassohn and Pick were more fortunate, and a reference to their results will be made in discussing the histology.

In this case, as well as in those of these two observers, the changes in the epidermis were almost negligible, and amounted only to a slight parakeratosis around the sweat-pores, the horn-cells at the orifices being a good deal swollen. Pick detected a few leucocytes between the prickle-cells in the neighbourhood of the sweat-channel through the epidermis, indicating a certain degree of dilation of the inter-epithelial lymphatic spaces, the result of cedema.

These observers found that the leading pathological changes were located in the corium. The blood-capillaries of the papillary and sub-papillary layers were markedly dilated, but the actual walls of the vessels were not affected (Pick). Around the capillaries there was a more or less dense cellular infiltration of a purely inflammatory type, and consisting of leucocytes, connective-tissue cells, a few mast-cells and an occasional plasma-cell. The fibrous elements of the corium were unaffected, and the pilo-sebaceous follicles appeared to be healthy. It was in the sweat-apparatus that the most definite changes were noted. The lumen of the sweat-coils was widened in an irregular fashion, and contained a finely granular *débris*, and the walls of the coils were thickened to several times their usual size (Pick). The sweat-ducts were not implicated to the same extent, and showed little or no change. Around the sweat-coils and ducts there were foci of cellular infiltration similar to that around the blood-vessels.

The general histological picture suggested to Jadassohn that it was a chronic inflammation which had its origin in the vessels around the sweat-apparatus. Herrmann, who also examined several of his cases histologically, was unable to detect these definite changes in and around the sweat-apparatus, and regarded the condition as a simple "peri-vascular disturbance of a purely inflammatory type."

Treatment.—The treatment adopted in this case was on general

principles with a view of improving the general health of the boy. Locally, various pastes containing salicylic acid have been ordered, and linament of belladonna has been painted on the nose in the hope of diminishing the hyperidrosis. The patient has been under observation for over a couple of months, but so far, in spite of the treatment, no distinct improvement can be detected in the local condition, though his general health has improved.

PREVIOUSLY REPORTED CASES AND NOMENCLATURE.

The credit lies with Luithlen* of first drawing special attention to this affection, or to one very closely allied to it. This he did in 1900 in Kaposi's *Festschrift*, where he described a case under the heading of "a peculiar form of acne, with changes in the sweat-glands." This case differs from those which have been described subsequently in that the papules were larger and actual cysts were present. It suggested an extreme case of the disease.

Six years before Luithlen's communication, Pringle demonstrated two undoubted cases at the Dermatological Society of London, on February 14th, 1894. These were recognised at the time as being peculiar, and were provisionally diagnosed as "hydrocystoma." The excellent description in the notes of these cases, which were kindly lent to me by Dr. Pringle, leave no doubt that they were cases of this affection. The patients were a girl, aged 12 years, and her brother, aged 10 years. In the girl's case the disease was "confined to nose, the tip of which was generally congested, and on this congested base were situated minute semi-gelatinous looking projections of a reddish-brown colour, very irregular in form, and varying in size from a pin's point to a rape seed. When the blood was expressed from the part by the finger, many of the lesions looked like tiny lupus nodules, while others were seen to be very richly traversed with blood-vessels. A small group of ill-defined lesions was situated on the inner side of the right eyebrow. There was much sweating of the face, especially of the nose and immediately surrounding parts." In the case of the boy, the "tip of his nose presented a similar appearance to that of his sister, but was not

* Luithlen, Kaposi's *Festschrift*, 1900, p. 709.

so well marked. The copious sweating of the nose, upper lip and eyebrows was as marked as in his sister."

It is to Jadassohn* that we are indebted for the title under which the disease now generally goes. He first observed a case of it in 1900 while he was assistant to Neisser at Breslau. At Berne he had the opportunity of studying several other cases, and in a paper in 1901 in the *Archiv f. Dermat. u. Syph.* he described and compared seven cases under the heading of "a peculiar disease of the skin of the nose in children," which he named "Granulosis rubra nasi." In this paper he also suggested as a histological alternative for this clinical name the title of "Peri-syringitis chronica nasi," or the more comprehensive and cumbersome name of "Dermatitis micro-papulosa (vel granularis) erythematos hyperidrotica chronica nasi."

The next series of cases were those recorded from Breslau by Herrmann† in 1902, with the title of "A peculiar inflammatory dermatosis of the nose of young individuals with sweating." He reported ten cases. These were clinically similar to those described by Jadassohn, but differed slightly in their histology in that in several of the cases Herrmann failed to find any definite change in the sweat-apparatus. Still more recently Walther Pick‡ reported a case at Prague, which was identical both in its clinical and histological characteristics with those described by Jadassohn. At the January meeting of the Dermatological Society of Great Britain and Ireland, Meachen§ showed a case of hyperidrosis of the skin of the nose in a boy aged 14. The report of the case somewhat suggests this disease, but in it the affected area was said to be "studded over with numerous small telangiectases," and no micro-papules are mentioned, whereas in all the cases of "Granulosis rubra nasi" telangiectases have not been a noticeable feature.

General remarks on the disease.—The clinical peculiarities and the histological changes associated with them are sufficiently constant and characteristic to warrant the assumption that Granulosis rubra nasi is an entity, and a sufficient number of cases have now been reported to permit of a few general statements regarding it.

* Jadassohn, *Archiv f. Dermat. u. Syph.*, 1901, LVIII., p. 145.

† Herrmann, *Archiv f. Dermat. u. Syph.*, 1902, LX., p. 77.

‡ Walther Pick, *Archiv f. Dermat. u. Syph.*, 1902, LXII., p. 105.

§ Meachen, *Brit. Journ. of Derm.* 1903, XV., p. 104,

The disease seems to be peculiar to young individuals, the greatest age in a case on record being in a girl of 16 years, reported by Jadassohn. The affection seems to disappear spontaneously when adult life is reached, no case having been recorded in an adult. It begins early in life, the case reported here commencing at about six months of age. It is doubtful if the sex has any bearing on the ætiology of the affection, still it is significant that six out of Jadassohn's seven cases occurred in boys. It affects weakly children who are poorly developed, nervous, anæmic, and sometimes scrofulous, and it is invariably associated with a weak peripheral circulation, made evident by cold cyanosed hands, feet, and lips, and hyperidrosis of these parts.

The course of the disease is singularly chronic, and so long as the hyperidrosis continues appears to be uninfluenced by treatment, for though the redness and the papules may be diminished by ichthyol and salicylic plasters and the like, the improvement is only transient, and the affection quickly recurs when the treatment is discontinued. As to the real nature of the disease, it suggests most strongly a simple inflammatory disturbance secondary to hyperidrosis and associated with a local vaso-motor derangement. The tip of the nose, like the lobules of the ears and the hands and feet, is one of the situations where the vaso-motor control is weakest, and any general circulatory disturbance is first evident in these acroteric regions. Still, although increased sweating is generally accompanied by dilatation of the blood-vessels, it is not necessarily so, and hyperidrosis may also be associated with the feeble circulation in a syncope. The nerve-fibres which induce sweating seem to act independently of the vaso-motor nerves, and to be under the control of sweat-centres in the cord and medulla. No definite reason could be found for the local activity of certain of these sweat-centres in this case, and an examination for sources of reflex stimulation of these centres, such as adenoids, gave negative results. Irritation in the cervical sympathetic has been shown from time to time to produce sweating (Raymond), and recently Purves Stewart* has described a case in which injury to the cervical sympathetic resulted in a paralysis of the nerve-fibrils to the sweat-glands and a cessation of

* Purves Stewart, *Brit. Med. Journ.*, June 8th, 1901.

sweating on that side. But no such cause of the local hyperidrosis could be discovered in this case.

Here not only the quantity of the sweat was locally increased, but its quality was altered, and it had become alkaline in reaction. Under ordinary circumstances the sweat over the whole body is acid in reaction, but in excessive sweating it becomes alkaline. This fact was demonstrated by Heuss* in the nose of a man, aged 18, who had a profuse local hyperidrosis which lasted six weeks.

Whenever a persistent localised hyperidrosis occurs it tends to set up inflammatory changes. In dysidrosis it has been suggested that the inflammatory disturbance is not secondary to the increased perspiration, but that the hyperidrosis only forms a predisposing factor, in that the excessive sweat becomes alkaline in reaction, and micro-organisms then being able to grow more freely in it are the real sources of the inflammatory reaction. In this connection Kasinow† reported an instructive case of hyperidrosis in a woman aged 25. It affected one side of the face, and had lasted for three years, and associated with it there was a diffuse hyperæmia, and the affected area was covered with small red papules. Kasinow considered it to be the result of a hysterical tropho-neurosis.

The affection has also a close analogy to *Miliaria papulosa* or "prickly heat," which is considered by certain observers to be an inflammatory disturbance localised around dilated sweat-coils and ducts, and the result of excessive sweating, while Török asserts that the vesicles of miliaria are purely inflammatory and independent of the sweat-apparatus.

The affection is not always confined to the nose, though this is the usual seat, it may affect also the upper lip as in this case, and one reported by Jadassohn, and both Herrmann and the former observer have recorded cases in which the cheek was also involved, and in Pringle's cases the eyebrows were implicated.

The differential diagnosis of the affection presents no serious difficulty, once the disease has been seen, and a laboured discussion on its points of difference from *Lupus erythematosus*, *Lupus vulgaris*, papular eczema, rosacea, hidrocystoma and dysidrosis are unnecessary.

* Heuss, *Monats. f. prakt. Derm.*, 1892, XIV., p. 843.

† Kasinow, *Russ. Med. Rundschau*, 1895, No. 20 (abstracted, *Monats. f. prakt. Derm.*, 1896, XXIII., p. 487.)

Suffice it that the absence of atrophy, scarring, and adherent scales preclude Lupus erythematosus; the age of incidence and the absence of telangiectases, and changes in the sebaceous glands differentiate it from rosacea; the local chronicity, absence of vesiculation and weeping, and of infiltration after years, and the fact that it is almost unaffected by local treatment distinguish it from eczema.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of the above Society was held on Wednesday, May 13th, Mr. MALCOLM MORRIS in the Chair.

The following cases and specimens were shown :—

Dr. W. J. FREEMAN brought forward a young married woman, aged 22, suffering from *Lichen variegatus*. There were four typical patches, the marbled appearance, with apparently healthy skin occupying the meshes of the reticulated macules, being everywhere well marked. There was a little scaling over the minority of the spots. Infiltration of the skin was absent. The largest patch occupied the upper region of the left thigh and corresponded pretty nearly with Scarpa's triangle. Smaller patches existed over the deltoid region of the left shoulder, over the upper half of the front of the left forearm, and over the front of the elbow joint of the right arm.

The disease had existed for seven years and has been slowly progressive.

Three years ago she was exhibited at a meeting of the Society by Dr. E. C. Perry, and a drawing was made of the condition as it then existed. The patch on the right forearm has appeared since then.

Near the edges of the patch on the left forearm papules can be observed at the present time closely simulating ordinary Lichen planus papules.

Subjective symptoms have all along been absent except as the result of the application of strong ointments. There is no history of heredity.

Dr. JAMES GALLOWAY showed (1) a case of a man, aged about 45 years, who had about five weeks previously presented himself at Charing Cross Hospital suffering from an eruption diffused over the trunk and extremities, consisting of large vesicles and bullæ.

These lesions were superficial in position and contained translucent serous contents. They arose from apparently normal skin; a few of them showed the finest possible fringe of redness at their bases. In addition to these lesions, which presented the characteristic appearance of *Pemphigus vulgaris*, there were seen a few circinate or round erythematous patches with slightly raised epidermis, having the appearance of abortive bullæ.

On the front of the legs there was a considerable amount of erythema, partly of the character already described, but which was accentuated by a slight degree of "varicose dermatitis." There were no lesions in the visible mucous membranes.

The patient had numerous defective teeth and well marked though not severe pyorrhœa alveolaris.

The general appearance of the malady at this time could well be described as *Pemphigus vulgaris*; but the lesions of erythematous nature raised the questions whether the condition was of the nature of *Erythema bullosum* or whether the eruption was an unusual manifestation of *Dermatitis herpetiformis*.

Local treatment of a protective nature was prescribed; directions were given for the mouth to be cleaned, and he received 30 gr. doses of salicin daily. He was unwilling to become an in-patient, and at the end of a week he returned to the hospital, stating that he felt better.

The bullæ so noticeable on the previous visit were fewer, but in addition an eruption was beginning to make its appearance, consisting of rings of erythema spreading peripherally, showing at their margin a well-marked continuous elevation of the epidermis. There were no herpetiform vesicles, but here and there the bullous lesions were obvious, and some of them of quite recent date. From this date to the time of his appearing before the Society his condition, so far as his own personal comfort was concerned, had improved continuously, and he now showed an eruption consisting of widespread gyrate patches of erythema, the circinate margins of which intersected, producing bold curved outlines. The central

portions of the lesions were now only slightly pigmented, the surface of the cuticle being intact. The pigmentation became deeper as the margins of the affected area were approached; the margins themselves consisted of lines about an eighth of an inch across of raised and ruptured cuticle, showing a slight degree of serous exudation. A few vesicles about the size of a pea were noticed beyond the circinate margins. The patient complained only of slight discomfort and itching; there was no pain, and he expressed himself as feeling well except for the slight amount of cutaneous discomfort.

The questions arose whether this acute eruption should be classified as pemphigus, as an example of bullous erythema, or an unusual variety of Dermatitis herpetiformis. It was pointed out that at no time during the eruption had there been herpetiform groups of vesicles, that the pain or discomfort had been of the slightest degree, and that the patient's health had only been slightly disturbed. •

On the other hand the early stage of the disease, which had been characterised by the eruption of bullæ, some of which were a couple of inches in diameter, had been complicated by lesions which could hardly be described otherwise than as examples of Erythema multiforme. From the clinical point of view, therefore, the case would be more accurately described as an Erythema multiforme with exaggerated vesication rather than a herpetiform dermatitis. His present condition, consisting of erythematous areas outlined by a continuous border of vesication, on the other hand, suggested to some members more close relationship with dermatitis herpetiformis.

This was the first attack of the disease in this case.

Dr. Galloway admitted the force of the arguments in favour of Dermatitis herpetiformis, but drew attention to the resemblance of the disease to the type of Erythema multiforme, and wished to draw attention to the fact that the administration of salicin appeared to be of considerable service to this patient.

The case would be kept under observation and reported on again if thought advisable.

(2) A married woman of about 34 years of age, who had been sent to him by his colleague, Mr. Charles Gibbs.

She presented around the nostrils, symmetrically on the lips, on both sides of the nose, and on the forehead, large lesions of a loosely

verrucose character. When she first appeared for treatment a fortnight previously, these lesions showed a considerable amount of pus-formation, and almost merited the name of cauliflower excrescences. They were situated on skin which was only very slightly indurated.

The history obtained was that the patient had suffered from primary syphilis six months previously, and during the lapse of time had shown various manifestations of generalised disease, but only on the face and scalp. She had been treated for some time before coming under observation with large doses of iodide of potassium, as well as by mercury internally. On account of the suspicion that the lesions were due in a greater degree to the administration of iodine than to the specific taint, all anti-syphilitic treatment had been stopped, and the patches of verrucose dermatitis had been carefully watched and treated by Dr. MacLeod with non-mercurial antiseptics; the result was good for the pus-formation, and much of the papillomatous overgrowth had vanished. But the lesions on the forehead, and especially at the nostrils, now presented more clearly their indurated bases, and the exhibitor had little doubt that the main factor in the disease was the syphilitic infection.

He wished to draw attention to the possibilities of the development of a framboesial eruption on the face, round the nostrils, and on the forehead in cases of syphilitic infection, while no manifestations were observed elsewhere.

No doubt this state of affairs was brought about partly by pyogenic infection, but the influence of the internal administration of iodine would certainly be likely to aggravate the lesions.

Dr. GRAHAM LITTLE showed (1) a case of *Asphyxia reticularis multiplex*, and (2) a case of *Pemphigus foliaceus*, both of which will be reported in detail in a later issue of the Journal.

(3) A case of *Lichen scrofulosorum* in a little girl the subject of advanced tubercular ulceration of the nose. Six years ago the child had the left eye removed at Moorfields Hospital for a corneal ulcer which was diagnosed as tubercular. The disease of the nose had commenced about two years ago and was of a rapidly necrotic type, so that the greater part of the skin and cartilage of the nose had already been destroyed by ulceration. She was under X-ray treatment for this condition. Four weeks ago the present eruption had

appeared on the trunk as groups of small, pink, rather spiny, papules. These groups varied in size from that of a sixpence to that of a five-shilling piece; they were very numerous on the back, where about ten such groups could be counted. They were smaller and rather fewer in number on the abdomen and chest, and one or two groups were to be seen on the upper part of the thighs, near Poupart's ligament. They gave rise to no subjective symptoms. The papules in the groups remained discrete throughout their course and were obviously follicular in position. A portion of the affected skin was excised from the back and sections showed much vascular dilatation and very considerable cell-infiltration round the hair-follicles, the cells seeming to be connective-tissue rather than leucocytic in type. No giant-cells could be seen and no other signs of tubercular architecture were visible in the sections.

(4) A case of *Psoriasis* with a concurrent attack of syphilis in a man, aged 30. The patient had had psoriasis for fifteen years, and was at the present time covered with an eruption characteristic of this disease. The date of the acquisition of the syphilis could not be ascertained, and indeed the patient, who is a stockbroker's clerk, denied all knowledge of this infection. But about six months ago some of the patches of psoriasis (with which he was thoroughly familiar) took on new developments and became ulcerated, and on admission to St. Mary's Hospital about three weeks ago some twenty or more ulcers, varying in size from that of a shilling to that of a half-crown, were noted on the back, the arms, and the legs. These, according to the statement of the patient and according to the observation of the exhibitor, had developed in the site of perfectly typical patches of psoriasis. He had not had any treatment of any kind for some months before his admission. The ulcers healed rapidly under treatment with simple antiseptic dressings, and it was only after these had nearly completely healed that he was given anti-syphilitic treatment. But he had evidence of previous ulcerated sore throat, with some loss of tissue in the anterior pillar of the fauces on the left side, and he had on admission a nodule on the forehead which looked rather like a syphilitic lesion, and which was excised and the sections showed characters typical of syphilis. The psoriasis, except for the fact of ulceration in some of the patches recorded above, was not appreciably modified by the concurrent syphilis. In

the site of some of the ulcers which have now completely healed over patches of psoriasis are again appearing.

Dr. J. J. PRINGLE exhibited (1) a man, aged 46, by occupation a gardener, sent up for opinion and treatment by Dr. T. E. Lloyd, of Abergavenny. He presented four granulomatous and ulcerating lesions of the face, highly suggestive of the diagnosis of *blastomycetic Dermatitis*, and the scars of numerous similar lesions which had been successfully destroyed by pure carbolic acid. The first manifestation of the disease occurred in September, 1901. The principal growth has been excised from the cheek, and will be subjected to microscopical examination.

(2) A highly neurotic woman, 47 years of age, who had undergone several pelvic operations at the hands of gynaecologists. When she first came under the exhibitor's observation in January, 1903, she presented a lamentable condition of the most severe pus-infection, involving the thighs and trunk with its maximum of intensity about the genitals. After two months of persistent boric bath treatment and other antiseptic measures, the essential lesions could be to a large extent differentiated. These consisted of minute papules, closely aggregated together in indeterminate groups, and so itchy as to be destroyed by scratching immediately on their appearance. Where the eruption had cleared up—*e.g.*, over a great part of the trunk—a marked ringed pigmentation had resulted, many of the dark rings surrounding pale, atrophic areas. Despite the impossibility of detecting actual vesicles, all members present agreed with the exhibitor in regarding the case as one of *Dermatitis herpetiformis*, although of anomalous type.

Dr. SEQUEIRA showed a girl, aged 18 years, with a peculiar *linear eruption* upon the right side of the face. The condition is said to have started when the patient was 9 years old, after a scratch. The lesions commenced just below the right ear and extended in a curved direction towards the chin, being limited in front exactly by the middle line. There were two lines for the most part quite close together. The lines were made up of a number of small papular elevations of a red brown colour, and individually resembled the lesions of *Lupus vulgaris*. The case was shown for diagnosis, and there was considerable difference of opinion amongst the members

present. By some the condition was looked upon as *Lupus vulgaris*, but by others it was considered to be a *Nævus unius lateris*, despite the fact that nothing had been noticed until the girl was 9 years old. It was agreed that a definite diagnosis could not be made without a biopsy, and this Dr. Sequeira undertook to obtain if possible. The patient had been treated for some months by the Finsen treatment without any benefit.

Dr. STAINER showed a case of *Mycosis fungoides* apparently cured by X-rays. The case was shown at the Society on March 11th (*Brit. Journ. of Dermat.*, April, p. 137). Since that date all the lesions had vanished under the influence of the X-rays.

The treatment was commenced by Dr. Greg on March 12th, and a rest was ordered on March 21st, after nine sittings. Each lesion was subjected to the rays for ten minutes, with old focus tubes, 8 to 10 inches from the skin. A current at 60 volts from the main was used, with an electrolytic break and a 16-inch coil. A current of about 10 amperes passed, which perhaps was unnecessarily large, but on a few occasions 16 volt accumulators were used with the platinum break, the current being about 4-5 amperes. For the lesions on the neck, forehead and cheek a high vacuum tube was used, the highest in which a good illumination could be obtained. For the remaining lesions a rather low tube was used with some blue visible behind the anode—about the condition for radiography.

Under this treatment improvement was detected as early as the fourth day, there being a definite shrinking of all the infiltrated lesions, and a marked flattening of the large tumour on the neck.

On March 21st the healthy skin surrounding the lesions on the neck and in the axilla began to show the effects of exposure, and on March 22nd was the seat of a well-marked erythematous dermatitis, which desquamated freely a week later.

In the axilla there appeared in addition a linear blister around the edge of the erythematous area for about a quarter of its circumference, but this soon healed. On April 3rd it was decided that the regions affected with the X-ray dermatitis should have further rest, but treatment was resumed for the remaining lesions on the face and back.

This further treatment, which produced no dermatitis, lasted up

to April 23rd, with fourteen sittings of seven minutes' exposure. During this time all the lesions were rapidly disappearing, but in the case of the large lesion on the back of the neck, although it was vanishing in an astonishing manner, there were signs of deep suppuration in its lower half. This led to the suppuration of a posterior cervical gland on the right side, which was opened and drained on April 23rd, and again an incision was made in the tumour itself on April 28th to free some pus which had been discharging from a small sinus.

To sum up, the lesions which were present on March 11th have all disappeared. For the lesions on the back of the neck (the large tumour) and in the axilla there were only nine exposures, whereas the remaining lesions had twenty-three exposures to the rays. The areas of skin, which were previously occupied by the lesions, appear perfectly normal, except for a rather deep pigmentation; and on the back of the neck there is some desquamation, an absence of hair, with some slight infiltration where the suppuration had previously occurred.

Dr. STOWERS exhibited a female patient, aged 83 years—a full report of the case having been published in the *Brit. Journ. of Dermat.*, December, 1901, p. 470, *et seq.*—who had suffered for seventeen years with an extensive *malignant papillary Dermatitis* (Paget's disease) involving the entire surface of the left breast. When shown in December, 1901, the surface was alone affected, so far as it was possible to judge, the gland structure being soft and elastic as in health. During the last twelve months several nodular growths had developed in the substance of the mamma of the nature of carcinoma, and lately secondary ulceration had taken place through the integument in connection with, and immediately over the site of the largest nodule. The axillary glands on the corresponding side were now involved, and severe lancinating pain was complained of. On account of the advanced age and enfeebled health of the patient removal by surgical operation was contra-indicated.

(2) A well-marked case of *Erythema multiforme* in the person of a boy, aged 15 years. The patient, who was the youngest of five children and stated to be delicate in health, had been the subject of

the disease for upwards of nine years. During this period intermissions of two or three months had occasionally occurred, but he was seldom without some lesions upon the skin or mucous membranes.

The first development occurred upon the thighs and legs, when "blisters the size of walnuts were noticed." Subsequently he has had numerous manifestations, chiefly upon the hands and forearms, and frequently on the skin around the mouth and on the buccal mucous membrane within. At this time numerous large macerated blebs are visible in the oral cavity, including the edges of the tongue. Much dental caries exists, but the lad is not liable to chilblains.

The variety of the disease known as Erythema iris is particularly marked about the flexor surfaces of the forearms and hands. The trunk and legs are less frequently involved. Vesicles are stated to have appeared from time to time upon the ocular conjunctivæ, accompanied by much inflammatory congestion of the membrane.

Both parents are living and in good health, but the father has suffered functional disorders of the nervous system.

No history of disease of the skin in any other member of the family is admitted.

Dr. WHITFIELD showed a man suffering from *multiple tubercular affections*. The history showed that he had been in perfect health until August, 1902, when he had suffered from a sharp febrile attack which had been diagnosed as rheumatic fever. Shortly after his recovery from this he noticed two red patches on his face, on the centre of the upper lip and the chin respectively. Very few weeks after the appearance of these patches he began to have trouble in his eyes, and on consulting an oculist he was found to be suffering from tuberculous iritis. Again, a month or two later, his legs gave him trouble, and bluish-red indolent lumps formed all round the legs below the knees, some of them softening and bursting. In this state he came to King's College Hospital. The patches on the lip and chin were circumscribed infiltrated swellings of moderately soft consistency, and on pressing out the blood they showed a yellow colour with definite deep transparency, so that although individual nodules were difficult to make out there was no doubt that the disease was lupus. On the legs when first seen there was a very marked reticular

blue marking all over, and at points of the blue marking there were large nodes the size of hazel nuts. Some of these were open at the back of the legs, but there were no large ulcerations, only small losses of tissue covered in by thick adherent scabs. He was treated by the small arc lamp for his face, and his legs were dressed with a mercurial ointment and firmly bandaged. The results of both these forms of treatment had been very favourable, the patches on the face being greatly reduced and the nodes on the legs much fewer. This was no doubt largely due to the better constitutional condition, since the oculist reported that the tubercular disease of the iris was melting away, and indeed the eyes had almost returned to the normal. The diagnosis offered was lupus of the lip and chin and nodular tuberculides of the legs. A point of interest was the presence of the progressive lesions on the face, as it was unusual to find tuberculides develop into the lupus form. It was, of course, possible that these had been primary inoculations, but the history suggested some general infection before the occurrence of the cutaneous lesions.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, April 22nd, 1903, Dr. STOWERS in the Chair.

The PRESIDENT announced that at the annual meeting in May, Dr. Corlett, of Cleveland, Ohio, would read an address on "The Present Epidemic of Small-pox throughout the United States, together with a short consideration of the different types of the Disease, their Recognition, and the Influence of Vaccination; Illustrated by Lantern Slides."

The following cases were exhibited :—

Dr. ABRAHAM showed (1) *a case for diagnosis.*

The PRESIDENT thought a water-colour drawing ought certainly to be made of this case for the Society's album; also that the case should be carefully watched, on account of the possibility of malignant growth, a possibility which should be borne in mind when making the microscopical examination. Meantime the iodide might be given in increasing doses and the effect watched.

(2) A woman, the subject of *follicular Dermatitis*. The patient

attended the West London Hospital on the previous day with an eruption on the back, the shoulders, and the chest, which had commenced less than a week before. There was much itching. It was either follicular eczema or a commencing Pityriasis rubra pilaris of Devergie, or possibly a Lichen scrofulosorum. A scar was present in the neck at the site where a tubercular gland had been removed in early life. Her mother died from phthisis. She did not present the typical condition of palms of the hands or the scaly face and scalp found in Devergie's Pityriasis rubra pilaris. Until the previous day she had had no treatment. He ordered creolin lotion, which had considerably allayed the irritation, and an ointment which had already to some extent smoothed the skin. Before this treatment was commenced the "nutmeg-grater" condition and follicular keratosis were very prominent.

The PRESIDENT thought the history of only one week suggested an accidental condition. He believed it to be follicular irritation, really papular eczema so-called, established upon a naturally dry skin, as evidenced by the somewhat xerodermic condition of the skin of the legs. She wore the same garment next the skin day and night, thus opening up many possibilities.

Dr. NORMAN MEACHEN showed a case of *symmetrical Sclerodactylia and Scleroderma* in a single woman, aged 59. The disease commenced five years ago with slight tingling sensations in the fingertips, upon which small "whiteheads" began to appear and subsequently to break. The skin then began to get tight, and the joints gradually stiffened. With the exception of an "ulcer of the cornea" ten years ago, she has had good health, and there was nothing noteworthy in her family history. About four years ago she noticed a "hard place" in the skin in the middle of the back of her right fore-arm, which was soon followed by a similar, though slighter, patch on the opposite side. She keeps a small fancy shop, and the only inconvenience she experiences is a difficulty in holding a needle, and in performing other fine movements. The fingers also tingle sometimes, and her feet are somewhat tender.

The changes are most marked in the index and middle fingers of the right hand, though both sides are affected. The distal interphalangeal articulations are ankylosed; the superjacent integument is tense, reddened, and in places shiny. The soft tissues covering the distal phalanges are atrophic, and the nails are thickened

and much shortened antero-posteriorly. Sensation to touch, heat and cold is preserved. On the extensor surface of the right fore-arm is an irregular patch of infiltration resembling a calcareous nodule, while on the opposite side is a patch of sub-epidermic infiltration about two inches in the longest diameter, the skin being adherent to the subjacent tissues. She has not the chilblain circulation, and there are no indications, past or present, of Raynaud's disease. The pulse is, however, intermittent and of increased tension. The ulnar nerves are not thickened. The knee-jerks are present. No treatment had been adopted for the condition.

The PRESIDENT asked Dr. Meachen to give the Society an opportunity of seeing the case again. The special feature was the limitation of the condition to the hands and the fore-arms. He showed coloured drawings of a case which seemed very similar, one of generalised symmetrical scleroderma, which was reported in the "Transactions of the Dermatological Congress of 1881." In that, the integument of the hands was so tight that it prevented work. Owing to its long duration—20 years—the phalanges became absorbed by pressure, and the picture showed a remnant of finger nail attached to the second phalanx. The condition in the face also was very marked indeed, and the skin was so much contracted as to cause spaces around the eyes. There were also many telangiectatic spots on the face. Dr. Meachen's case seemed not unlikely to be one of Raynaud's disease.

Mr. HITCHINS considered that it was probably a case of Raynaud's disease.

Mr. GEORGE PERNET said that Sclerodactylia might commence somewhat in the way of the case before them, but he did not consider Dr. Meachen's diagnosis was made out. Raynaud-like phenomena might precede Sclerodactylia. With regard to the symmetrical lesions in the fore-arms, they were apparently of the nature of calcareous deposits. The recurrent whitlows on the fingers were suggestive of Morvan's disease, although they were painful in this case. They were not always painless. Mr. Pernet asked if Dr. Meachen had examined the patient's sensations from the point of view of Syringomyelia? Another point was that the condition was also very suggestive of leprosy. Mr. Pernet elucidated the fact that the patient had, some years before the disease commenced, spent three months in Italy, including Genoa and the Ligurian coast, and on the Riviera, where leprosy still existed.

Mr. JOHN PERKINS (introduced), who had seen some practice in India, was of opinion that the finger-ends had a very suggestive look of leprosy, and had he seen the patient in India he would have suspected that disease. He had formed this opinion before the fact of any residence abroad had been elucidated.

Mr. ARTHUR SHILLITOE showed *a case for diagnosis*. A young man, aged 25, acquired syphilis last October. All the symptoms cleared up under treatment. In February last he somewhat suddenly

developed an irritable, red, eczematous eruption which, starting on the fronts of the thighs, rapidly spread up the trunk and down the arms to the fingers. When first seen a fortnight ago at the Hospital, the appearances observed in the clefts between the fingers and fronts of the wrist so closely resembled those of scabies that he was given ung. sulph. and ordered to continue specific treatment, his throat being markedly ulcerated. A week later the hands were better, but the general eruption, especially on the thighs, remained intensely irritable.

The PRESIDENT thought the case was one of *Lichen circumscriptus*.

Dr. STAINER said the facts that it was essentially a ringed eruption, that the margins were papular, and that the centres were of a brownish colour, showed it to be a case of Unna's seborrhoic eczema.

Dr. WILFRID WARDE showed, for Mr. WARREN TAY, a man, aged about 40, with an *ulcer* on the left leg. He had typhoid fever eighteen months ago, followed by double phlebitis. The left leg and thigh were still much swollen. Six weeks ago a round, deep, punched-out ulcer developed, looking like a gummatous lesion, but no evidence of syphilis could be found. The ulcer had now filled up considerably; previously there was a fungating mass in it. It was said to have originated as a hard, round lump. There was no history of any injury, and he looked upon it as a necrosis, possibly direct, caused by the *Bacillus typhosus*.

CLINICAL NOTES.

TWO CASES OF ACUTE PEMPHIGUS OF INFANTS.

BY ARTHUR WHITFIELD, M.D., M.R.C.P.

CASE 1.—A child was brought to King's College Hospital by its mother, on account of an eruption of blisters all over the body and limbs. The age of the child was seventeen days, its general health was good, and the mother said that she had first noticed the eruption four days previously on bathing the child. She was confident that there were no other cases of skin eruption in the house, but she had her-

self developed a blister on the forehead two days ago, that is, two days after the appearance of the eruption on the child. On examination the child exhibited a number of tense thin-walled bullæ, varying in size from that of hemp seed to a large pea, filled with clear straw-coloured serum and not surrounded by any redness. On the forehead of the mother was a typical lesion of *Impetigo contagiosa* with a flaccid greyish covering and a scabbed centre. Cultures were taken from the unruptured vesicles of the child, and from beneath the undermined edge of the lesion in the mother. Those from the child gave initially pure cultures of streptococci, while that from the mother gave an almost pure culture of streptococci, containing a few colonies of *Staphylococcus pyogenes aureus* when transferred to a solid medium after twenty-four hours' growth. Both cases yielded at once to mild antiseptic application.

CASE 2.—This case is one which would almost certainly be classed under the heading of *Dermatitis exfoliativa neonatorum* by those who recognise the disease as a separate entity. A child aged just under a fortnight was brought to the Great Northern Central Hospital on account of a wide-spread eruption. The mother gave the history that the child was perfectly well five days previously. It then began to show red patches on the face, these peeled and similar patches appeared soon after on the body and limbs, so that in three days it was almost completely covered with the eruption.

The child had been well up to the morning when she brought him to the hospital, but on that morning he had vomited once or twice apart from feeding. He was breast-fed, the mother was healthy, and there was no evidence obtainable of any similar eruption in the house, while an examination of the mother showed a perfectly sound skin. On examination it was found that the entire body and limbs, excepting the palms and soles, were involved in the disease. The skin was of a dusky red colour and the horny layer hung in shreds all over, leaving only a few healthy islands on the lower parts of the abdomen. Where the horny layer had become stripped off, the surface was raw looking and shiny, but discharge was not marked, and there was very little tendency to crust formation. On careful examination it was found that the edges of the desquamating areas were in reality formed by the most flaccid of bullæ, with a very small amount of viscid discharge beneath them. The temperature was

normal, and the child seemed extraordinarily little affected by its extensive skin disease. It was however, judged advisable to admit the child at once and this was done, the mother being taken in as well since the child was breast-fed. The treatment adopted was to wrap the whole of the body and extremities in a weak antiseptic paste and cover it thickly with cotton wool, but the child died suddenly about five hours after admission. A post-mortem examination held on the following day revealed no gross disease of the internal organs, and a piece of skin from the edge of the desquamating lesions was removed for examination. It is unfortunate that no cultural examination was made when the child was first seen, but I had run out of tubes at the time. The chief interest in the histology lay in the enormous dilatation of the superficial blood-vessels beneath the epidermis. These were expanded to several times their normal diameter and distended with blood. No perivascular or other infiltration was found in the skin, nor was there any special emigration of leucocytes. The deep epithelium was somewhat oedematous, and the superficial horny layer was raised in sheets from the subjacent layers. Beneath this raised horny layer and in every crevice were masses of cocci which stained well by Gram's method, causing a very striking appearance when examined with a moderately high power. They did not exhibit any chain formation, but they were rather small. None were found in the deeper layers of the epidermis nor in the true skin, and I think, therefore, it may be assumed that their presence was not due to agonal infection. That they were the cause of the disease is, I think, moderately certain, but their nature, as to whether they were streptococci or staphylococci, could not, of course, be determined without cultivation.

Cases of acute Pemphigus neonatorum associated with Impetigo contagiosa lesions of adults are now so well known that the disease has rightly been separated off from the pemphigus class by most authorities, and put into that of the pus infections. It is still remarkable, however, that most of those who have examined bacteriologically the serum of vesicles, have described a staphylococcus as the organism present. Those who have carried out systematic controls of the work of Balzer and Griffon, such as Sabouraud, Gilchrist and myself, seem to be in agreement that the impetigo bulla of Tilbury Fox has as its characteristic organism the streptococcus, and one would therefore

expect the same organism to be present in the acute pemphigus of infants. In two cases in which I have had carried out culture experiments—namely, one of these above reported, and one other—the streptococcus was obtained. In the fatal case reported here I was unfortunately not able to inoculate at once, and the opportunity was lost.

As regards the nomenclature of this fatal case, the position of the so-called Ritter's disease seems very uncertain, some of the German observers maintaining that it is a distinct entity, while others class it with the acute pemphigus of infants. The case reported certainly corresponded well with the description of Ritter's disease, but the histological examination would bring it into the class caused by pus cocci, and this is, I believe, the general view generally held in this country, where no case seems to have been reported under the name of *Dermatitis exfoliativa neonatorum*. The extraordinarily rapid death of the child in a few hours after I first saw him in apparently good condition, was very striking, and all such cases should, I think, be treated with the utmost caution if much surface is involved, no matter how slight the constitutional symptoms appear.

CURRENT LITERATURE.

ON *DERMATITIS PSORIASIFORMIS NODULARIS (PITYRIASIS CHRONICA LICHENOIDES)*. J. M. HIMMEL. (*Archiv f. Dermat. u. Syph.*, April, 1908, LXV., p. 47.)

SINCE Jadassohn first demonstrated his case of "Dermatitis Psoriasiformis Nodularis" at the fourth German Dermatological Congress, cases have been reported by Neisser, Juliusberg (8), Rona, Pincus, and Herscheimer. As this is a rare affection and one which has recently been confused with other diseases of the skin, the present communication of Himmel merits more than a passing reference. The patient was a well-nourished young woman, aged 26. The eruption began several months before she presented herself for examination at the clinic. It commenced as red scaly macules about the size of small peas. The eruption was unaccompanied by subjective symptoms. The face, neck, and hands were free of it, but it was present to a greater or less degree over the rest of the skin, being most marked on the inner aspects of the arms, on the breast, especially in the neighbourhood of the mammæ, and on the legs about the knees, calf, and dorsum of the foot. The lesions were irregularly distributed, and showed no tendency to coalesce or to form a network. They varied in size from a pin's head to a lentil,

and were round or oval in shape. The fresh lesions were intensely red, smooth round papules. On the lower extremities they assumed a bluish-red tint, and were here and there slightly hæmorrhagic. Scratching of the surface of the lesions showed the presence of a fine scale, but did not cause bleeding. The writer distinguished three stages in the evolution of the lesions; (1) the rounded resistant papule covered with a fine scale; (2) a flatter papule from which the scale had come away except at the border, where it surrounded the lesion like a collar; and (3) lesions level with the skin from which the infiltration and redness had almost disappeared. No atrophy, scarring, or pigmentation resulted. Numbers of lesions in all stages of this process of evolution could be detected. The histological examination of two of the papules gave the following results:—In the majority of the sections there was a dense inflammatory cellular infiltration in the papillary and sub-papillary layers; cellular foci were also localised around the blood-vessels, pilo-sebaceous follicles, and sweat-coils, and there was œdema of the papillary layer. The walls of the blood-vessels were normal, and the collagen and elastic fibres were healthy. In the epidermis the horny layer was thickened and showed distinct parakeratosis, and the keratohyalin was diminished in the granular layer. This clinical and histological picture was identical with that of Jadassohn's original case.

The writer then reviews the literature on the subject. He noted that Neisser named his case a "Psoriasiform and Lichenoid Exanthem," and Juliusberg called it "Pityriasis chronica lichenoides," but prefers the original name. He referred to the grouping of Fox and MacLeod—namely, including this affection with Parakeratosis variegata and certain others to which it is allied, under one heading.

But though the disease may be grouped with "Erythrodermie pityriasique en plaques disséminées" and "Parakeratosis variegata," the writer, with Jadassohn, justly protests against their being regarded as identical.

J. M. H. M.

A CASE OF ATROPHY OF THE SKIN AFTER EXPOSURE TO THE RONTGEN RAYS. H. E. SCHMIDT. (*Archiv f. Dermat. u. Syph.*, January, 1908, LXIV., p. 15. One Plate.)

THE Plate which illustrates this short paper is the reproduction of a photograph of the back of a hand, the skin of which appears markedly atrophied, like the skin which occurs in the so-called "Atrophia cutis idiopathica." This condition of the skin was the result of an exposure of the hand to the Röntgen rays for half an hour in taking a skiagraph. Two or three weeks after the exposure the exposed skin became red. This colour gradually darkened till it became of a bluish tinge, and finally atrophic changes supervened and the skin became like "wrinkled cigarette paper." This change took place without any œdema or vesiculation. The atrophy has remained permanent for five years.

J. M. H. M.

ON THE HISTOLOGICAL CHANGES PRODUCED ON LUPUS VULGARIS BY THE FINSEN LIGHT. SCHMIDT and MASCUSE. (*Archiv f. Dermat. u. Syph.*, March, 1908, LXIV., p. 828. Two Plates.)

THIS contribution is based on a histological examination made on three cases of Lupus vulgaris during treatment with the Finsen light. It will be unnecessary to

refer in detail to the pathological changes which were observed in the tissues, as they correspond with those described by Sack in the *Münch. Med. Wochenschr.*, April, 1902, and with those by MacLeod which are reported in detail in the *Brit. Med. Journ.*, October 25th, 1902.

They note, as the essential factor in the curative process, the more or less intense inflammatory reaction, and believe that the chief effects on the lupus-tissue are the result of the inflammation. If this reaches a certain degree, degenerative and even necrotic changes may supervene. They note in pieces of tissue some time after exposure, that a process of repair has set in which is made evident by the presence of new connective tissue spindles, and which culminates in the formation of the excellent scar which is the leading feature of this form of treatment.

"PSEUDO-XANTHOMA ELASTICUM" AND "COLLOID DEGENERATION, IN SCARS." EMMA DÜBENDORFER. (*Archiv f. Dermat. u. Syph.*, February, 1903, LXIV., p. 175. One Plate.)

THROUGH a fortunate coincidence the writer had recently the opportunity of studying a case of Pseudo-xanthoma elasticum, and two cases of Colloid degeneration in scars, and of comparing the two conditions histologically. The Pseudo-xanthoma elasticum occurred in a boy, aged 7 years, in the gluteal fold in the form of short stripes and flat yellowish papules only slightly raised above the level of the surrounding skin. A histological examination of a piece of tissue excised from one of the lesions revealed the usual characteristics of Pseudo-xanthoma elasticum, and showed foci of thickened elastic fibres. No "xanthoma cells" were noted. The case of colloid degeneration corresponded in every detail to those described by Juliusberg (*Archiv*, Bd. LXI., p. 175, and abstracted in *Brit. Journ. of Derm.*, XV., p. 89). In them a different type of degeneration was found, the elastin has become transformed into elacin, and the collagen had swollen up and become transformed into "colloid." Juliusberg considered that the same type of degeneration of the fibrous elements occurred in both the affections. The writer believes that colloid milium and Pseudo-xanthoma elasticum differ histologically to a slight degree in the type of degeneration which occurs, but to a more marked extent, in the localisation of the lesions in the cutis, for in the colloid milium the degenerated places were very superficial and situated in the papillary body, while in the Pseudo-xanthoma elasticum the foci were detected deep down in the pars reticularis. (This may be a coincidence.)

J. M. H. M.

ON CALCIFICATION OF THE SKIN. THIMM. (*Archiv f. Dermat. u. Syph.*, October, 1902, p. 168. Three Plates.)

In this interesting communication the author describes a peculiar case in which there was present on the dorsal aspect of the proximal phalanx of the left little finger of a man, aged 23, a hard raised disc-like tumour, about 1 c.m. in diameter, and having a whitish-yellow colour. The lesion was somewhat warty in the centre, and on careful examination proved to be formed by the coalescence of a number of small whitish nodules about the size of hemp-seeds. This lesion had taken nearly eight years to grow. It was excised and a skin-graft was performed and healed without much scarring. On microscopical examination it was found that the skin,

and chiefly the cutis, was studded with calcareous deposits. These were largest in the situations of the pilo-sebaceous follicles, but smaller deposits were also present between the fibrous bundles of the corium. The fibrous elements in places formed a network supporting these chalky deposits. Associated with these deposits there was a chronic inflammatory process affecting the corium, especially around the follicles. This was made evident by the presence of a large number of multinucleated cells. Several of the sebaceous follicles were much distended, forming cysts containing the calcareous matter. In the epidermis a few small deposits could be detected among the prickle-cells. The writer considers the condition to be the result of a sebaceous gland change with the formation of retention cysts, the contents of which had undergone calcification.

J. M. H. M.

STUDIES ON SMALL-POX. SANFELICE and MALATO. (*Archiv f. Dermat. u. Syph.*, October, 1902, p. 189. Three Plates.)

DURING the epidemic of small-pox which occurred in the province of Cagliari in 1898 the writers had the opportunity of examining, both histologically and bacteriologically, material from seven post-mortems of cases of small-pox, and it is on these examinations that the present contribution is based. A bacteriological examination of the dried-up contents of pustular lesions showed that the *Staphylococcus pyogenes aureus* was invariably present, and that it was associated with one or more of the following bacteria:—the *Staphylococcus pyogenes albus*, the *Staphylococcus pyogenes citreus*, the *Bacterium coli*, a bacillus like that of typhoid fever, Friedländer's pneumobacillus, and the *Diplococcus lanceolatus*. From the internal organs pure cultures of the *Staphylococcus pyogenes aureus* were obtained in five cases, while in two of them they were associated with several of the above-mentioned bacteria. The *Staphylococcus pyogenes citreus* was never obtained from the internal organs. Inoculation of material from the various cases in dogs produced symptoms similar to those caused by the *Staphylococcus pyogenes aureus* in man, and this micro-organism was obtained in pure cultures. When cultures of this staphylococcus were injected into the veins of a dog the result was fatal, and it caused hæmorrhagic spots and necrotic foci to appear in the kidneys, lungs and skin, and swelling of the liver and spleen—appearances somewhat similar to those in hæmorrhagic small-pox in children.

Cultures of the other micro-organisms isolated had little or no pathological effect when injected into animals, and the writers came to the conclusion that it was only the *S. pyogenes aureus* which caused the symptoms like small-pox when material from a small-pox case was injected into the veins of a dog. The writers also found that animals such as the sheep, dog and rabbit, which had been vaccinated with cow-pox lymph, were not rendered immune to the action of this staphylococcus if it were injected into the veins.

J. M. H. M.

RETICULAR SUPPORTING NETWORK IN MALIGNANT NEOPLASMS AS STAINED BY MALLORY'S METHOD. P. G. WOOLLEY. (*Bull. of the Johns Hopkins Hosp.*, January, 1908, p. 21.)

IN September, 1900, W. C. White contributed to the above journal an important histological paper on the distribution of connective tissue in new growths, in which

he described a fine intercellular reticular network in sarcomata which was similar in structure to the reticulum present in normal glandular tissue, and pointed out that although carcinomata possessed a white fibrous tissue stroma outlining the cell-spaces, they had no intercellular reticulum. Woolley in this paper corroborates and amplifies White's observations. The technique he employed was a modification of Mallory's method. The tissue was hardened in Zenker's fluid, embedded and cut in paraffin, and the sections stained for a few minutes in one-tenth per cent. aqueous solution of acid fuchsin, washed in water, differentiated in 1 per cent. phospho-molybdic acid from five to seven minutes, again washed in water and then counter-stained in a composite stain composed of aniline-blue 0.5 grams, orange G. 0.2 grams, and oxalic acid 2 grams, with 100 c.c. of water. The slides were then rinsed in water, dehydrated in alcohol and cleared in aniline oil and xylol. By this method the finest reticular processes were clearly demonstrated.

He found that an intercellular network was absent in the carcinomata, but that it was invariably present in the sarcomata and in the endotheliomata, showing the close relationship which exists between the two latter neoplasms. This intercellular reticulum the writer regards, with White, Johnston, and others, as the result of newly-formed fibres, and not simply as due to the presence of the more or less attenuated reticulum of the normal tissue into which the cells have penetrated.

J. M. H. M.

**FURTHER CONTRIBUTION ON SARCOMA IDIOPATHICUM MULTIPLEX
PIGMENTOSUM CUTIS. BERNHARDT. (*Archiv f. Dermat. u. Syph.*,
October, 1902, p. 287.)**

Two years ago the writer of this paper published a description of the histology of the skin in Sarcoma idiopathicum multiplex pigmentosum cutis (Kaposi), in which he concluded that this type of sarcoma took its origin in the perithelium of the blood-vessels and was a true angio-sarcoma. Since then he has had the opportunity of studying three more cases of this rare disease, especially with regard to the histology, and has been able to confirm his original opinion regarding it. In this contribution these three cases are described in detail. In a summary of the leading clinical features of the three the writer comes to the conclusion that this disease generally makes its appearance first in the extremities and most frequently in the fingers or toes, and that it usually attacks one extremity first and rarely either both feet or both hands simultaneously. It begins as smooth reddish, occasionally brownish-yellow, macules associated with which a varying number of small deep-seated nodules may be felt in the skin. In places these nodules tend to become grouped and may coalesce to form lesions several centimetres in diameter. These nodules gradually increase in size till they become as large as hens' eggs or even larger. The skin over them becomes darker in colour and assumes a purplish tinge. These lesions are capable of involuting spontaneously. This takes place either by a process of atrophy or of degeneration. In the former case the nodules gradually shrivel and the epidermis over them becomes scaly and peels off, while in the latter the sarcomatous tissue becomes softer, the skin assumes a dirty bluish tinge, and the swelling gradually disappears. A few years after the nodules appear on the extremities similar lesions develop on the face, chiefly about the nose and eyelids. This generally does not take place for five or six years. The skin of the trunk also becomes implicated though the back is rarely so. Metastasis

to the internal organs generally takes place, and the cases are, as a rule, fatal. An interesting coincidence occurred in one of these cases. During the course of the disease an attack of erysipelas supervened. It was expected that this would have the effect of inhibiting the growth of the sarcoma, but instead of that it seemed to augment it, for while it was going on a number of new sarcomatous nodules appeared. A histological examination of early and late lesions showed that the vessels were much affected. The capillaries on the papillary and sub-papillary layers were widened and their endothelial cells were swollen and the nuclei larger. The vessels of the deeper layers of the corium and subcutaneous tissue were more markedly implicated. The endothelium had proliferated and also the perithelium and the tunica media was thickened and had undergone hyaline degeneration. Around these vessels were foci of spindle-shaped cells and long connective-tissue cells, with here and there a few plasma-cells, mast-cells, and leucocytes. The skin was pigmented, the pigment being chiefly present in the lymph-spaces of the corium, but also to a less extent within the spindle-cells. The sweat-apparatus and the pilo-sebaceous follicles were not affected. The writer did not detect any karyokinetic figures in the spindle-cells, but he found nuclei dividing amitotically. He concluded that from the influence of some unknown irritant in the blood-vessels the endothelium swells and the perithelium proliferates and that gradually sarcomatous foci form around the vessels while numerous secondary foci appear elsewhere, and that the type of sarcoma which developed was a spindle-celled angio-sarcoma.

J. M. H. M.

A CASE OF ANTHRAX OF THE SKIN WITH NOTEWORTHY CLINICAL APPEARANCES. HUGO HERRMANN. (*Archiv f. Dermat. u. Syph.*, October, 1902, p. 208. One Plate.)

A SHEPHERD and his boy, in killing and cutting-up a diseased cow, both wounded themselves, the one getting a cut with a knife, the other lacerating his forearms with the ragged ends of the animal's ribs. It was the boy who cut himself, and the wound bled freely and no subsequent ill-effects resulted from the injury.

The scratches which the shepherd had got did not bleed and it was he who developed anthrax. Three days after the injuries red nodules appeared on his forearms, followed by enlargement of the glands on both axillæ and swelling of the arms, chiefly the right one. At the same time the general health of the patient became impaired. He lost his appetite, had several rigors, became feverish and had some difficulty with his breathing.

At this time he came to the clinic at Breslau. The whole of the right arm was then swollen and œdematous and the skin was smooth and shiny. On the forearm and hand there were a number of variously-sized lacerations covered with scabs. On the extensor aspect there was a linear scratch about 15 c.m. in length, and on it was a row of nodules, several of which were capped by a small pustule. In the neighbourhood of this lesion a number of variously-sized nodules and pustules were situated on the œdematous skin. A few of the pustules were depressed in the centre and several were covered with hæmorrhagic crust.

Similar lesions, though fewer in number, were present also on the flexor aspect of the right forearm. The left arm was affected in much the same manner

though to a much less extent. In the sero-pus squeezed from the lesions anthrax bacilli were found, and cultivations and inoculations in animals confirmed the diagnosis.

The patient died two days after being seen at the hospital; that is, ten days after being inoculated with the disease. The post-mortem examination is described and also the histological examination of several pieces of tissue excised.

In spite of the severity of the infection the internal organs presented little or no abnormal naked-eye appearances. Sections of the skin of the nodules and pustules showed the presence of the Bacilli anthracis in enormous numbers in the corium.

These bacilli were lying free in the lymph-spaces and none of them were detected either in leucocytes or in any other type of cell. The writer specially notes this in connection with Metchnikoff's theory of phagocytosis.

J. M. H. M.

ON NODOSE SYPHILIDES ("ERYTHEMA NODOSUM SYPHILITICUM") AND SYPHILITIC PHLEBITIS. MAX MARCUSE. (*Archiv f. Dermat. u. Syph.*, November, 1902, p. 8. One Plate.)

IN 1880, under the heading of subcutaneous Gummata, Mauriac described a case of Erythema nodosum syphiliticum. Beurmann and Claude, more than ten years later, described the same condition as Erythème noueux syphilitique, but pointed out that it was quite different in its nature from ordinary syphilitic gummata. In this contribution to the subject Marcuse describes three cases. In all there was a definite history of syphilis, and undoubted "secondaries" were present and lesions similar to those described by Mauriac were detected.

A histological examination showed that a phlebitis was at the root of the disturbance. The lumen of the vessel was filled with granulation tissue and around it there was a dense small-celled infiltration with some plasma-cells, and here and there necrosis of the cellular mass could be detected. The condition was that of a Phlebitis proliferans et obliterans with the formation of granulation tissue and necrobiosis.

From his observations on these cases the author comes to the following conclusions:—

(1) In a few severe cases of syphilis, an eruption similar in appearance to idiopathic erythema nodosum may attack the regions usually affected by that disease; and this eruption is specific in nature and has been named by French dermatologists Erythema nodosum syphiliticum.

(2) The nodose syphilide appears usually in the first year after infection and is generally associated with other "secondary" manifestations, but takes a different course to them in that it softens and ulcerates. It reacts to some extent to specific treatment; still, the special action of mercury and iodine on it has not yet been sufficiently established.

(3) On clinical as well as histological grounds the original seat of the disease seems to be the subcutaneous veins, and the condition is analogous in many respects to the nodose "tuberculide" described by Philippson.

(4) On clinical grounds this condition falls into the category of an intermediary stage between the secondary and tertiary or gummatus manifestations of syphilis.

[This paper is singularly suggestive and merits a careful study, in view of the present diversity of opinion with regard to Erythema induratum of Bazin. It is to emphasize the fact that the phlebitis, which is the initial lesion in one type of Erythema induratum, that form which Philippson described as Phlebitis nodularis necroticans is not peculiar to tubercular affections, but may occur equally well marked in association with syphilis and possibly independent of both diseases—J. M. H. M.]

THE INFLUENCE OF LIGHT ON THE GROWTH OF THE HAIR AND ITS THERAPEUTIC ACTION ON ALOPECIA AREATA. H. E. SCHENK.
(*Archiv f. Dermat. u. Syph.*, October, 1902, p. 329.)

It is a well-known fact that it is necessary to shave and to have the hair cut more frequently in summer than in winter. In other words, that the hair-growth like that of the nails, is more active in the warm weather of summer. This fact has been explained as due to the action of the actinic rays of light, which are as every photographer knows, much more numerous in summer than in winter. It is the chemical or actinic rays which are obtained from a Finsen lamp, and if the writer's theory be correct repeated exposure to these rays ought to cause increased hair-growth. That this is the case has several times been remarked. Patches of skin repeatedly exposed to the Finsen rays have not infrequently shown a tendency to increased growth of hair limited to these patches, and in the Finsen Light Institute several of the nurses whose arms were almost constantly exposed to the rays presented a distinct hypertrichosis. This phenomenon the writer believes not to result from any specific action of the rays, but to be indirectly determined by the inflammatory reaction on the skin and the increased vascularity and better nutrition of the hair-follicles. He points out that X-rays also cause an inflammatory reaction, but one which is associated with defluvium of the hairs. This does not explain. (It has been remarked, however, that short exposure to the X-rays at long distances do not cause a defluvium but rather an increased growth of the hairs.) To try to establish this theory experimentally the writer experimented on two guinea-pigs. He epilated patches of equal size in each animal.

He placed one of them in a small box exposed to ordinary sun-light, while the other was placed in a box which had a window of red glass, which was only transparent to red, orange, yellow, and green rays, and through which none of the blue, violet and ultra-violet rays (the actinic rays) could reach the animal. He found that the altered environment with regard to light made no difference to the growth of the hair, in fact, that in the box with the red glass window the hair seemed to have grown faster in spite of the fact that the actinic rays were completely cut off. He repeated this experiment, with similar results, and concluded that the more rapid growth of the hairs and nails in summer has not been proved to be the result of the action of the actinic rays and regards it as much more probably due to the increased warmth causing an increased activity of the circulation and the secretory apparatus.

An experiment with regard to Alopecia areata is also recorded. A fresh patch of alopecia was treated by the Finsen lamp in the same manner as in Lupus, using a compressor. The patch was seven times exposed, for a quarter of an hour each time. No reactions occurred. In a few weeks the hairs began to grow on rapidly.

In another case two patches on the vertex of the scalp were exposed to diffuse rays from the lamp at a distance of one metre from the scalp. One of the patches was exposed twelve times and the other sixteen times. In this case the hair gradually fell out all over the scalp. These cases are not regarded as being conclusive.

J. M. H. M.

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ERYTHEMATA AS INDICATORS OF DISEASE.

The Annual Address to the Dermatological Society of Great Britain and Ireland, delivered on Wednesday, June 24th, 1903,

BY JAMES GALLOWAY, M.D., F.R.C.P.

MR. PRESIDENT AND GENTLEMEN,—I have chosen the subject of my address to the Society on account of the interest that it always has possessed for those interested in the study of Medicine, and to lay before you for your consideration certain recent observations. The subject is obviously too extensive to be dealt with in all its details in any single address, so that I have chosen a few special conditions only in illustration of my remarks, leaving indications given by erythematous eruptions in large groups of diseases quite undealt with.

Early Ideas concerning the Relations of Erythemata.—In certain diseases the occurrence of rashes forms such an important feature that they have been from early times recognised as indications of the disease, and sometimes appear almost to have overshadowed the disease itself.

The macular and punctate rashes are so striking in what we now know as measles and scarlet fever that in the early classifications of skin eruptions rubeola and scarlatina took an equal place on account of their skin eruptions with purpura and erythema. That this classification was not satisfactory to the very logical mind of Dr. Robert Willan is quite clear on reading his chapter upon the Exanthemata. In his definition of a rash (Exanthema) he says it "consists of red patches on the skin, variously figured, in general confluent, and

of a functional character, affecting the whole of the vascular mechanism.

Important Associations of the Simple Erythemata; Vascular Disturbances.—Perhaps the most common condition observed is a certain degree of tachycardia, as may naturally be expected if there is a considerable amount of diminution in the peripheral vascular tension. In one such case of extreme degree under my observation the pulse frequency for years was rarely below 100, and very usually the heart could be counted up to 150 or 160 per minute. To produce such a result, however, the dilatation of the skin arterioles over a large area seems to be necessary; and it is not an unusual observation to find that the individual showing the congested extremities has even a less frequent heart-beat than is normal, descending perhaps even to 4 beats per minute. Perhaps of more consequence than the functional cardiac disturbance, which I have just alluded to in these cases, is the very serious tendency for the skin itself to suffer injury. When the congestion is marked the tissues must be ill-nourished, and are apt to be œdematous. Physical injuries produce abnormally severe results, and the resistance of the tissues to pathogenic parasites becomes less. Perhaps the commonest agent in producing disease in these persons is cold. It is very usual to find that they suffer severely from chilblain, the result not of vaso-dilatation of central nerve origin, but a paralytic distension produced by local injury of the nerve muscular mechanism of the arterioles by cold. A lesion in many respects resembling chilblain, but due to other causes probably also physical, and terminating in the destruction of the influences which regulate the expansion and contraction of arterioles, has not unfrequently been observed. Many of these cases, I feel sure, have been described under the name "*Erythema induratum*."

Necrosis of Tissue.—At the meeting of this Society in March, 1899, I recollect remarking, *à propos* of a case of Bazin's disease shown by Dr. Abraham, that at least two conditions have been described in current dermatological literature under the name "*Erythema induratum*"—one a disease in which distinct nodules occur with a small-cell infiltration of the cutis, necrosis, and ulceration, frequently with serpiginous margins. The other was a condition in which the lesion was really œdema of the cutis associated with paralytic distension of the superficial capillaries also tending to end in necrosis

and ulceration. This opinion has been supported by other observations, and its truth can hardly be doubted.

Grave Disturbance of Nutrition.—I have recently had the opportunity of observing the most extreme case of simple erythema that I have ever seen or read of. The patient, a young woman, suffered for twelve or fifteen years from a general and almost constant congestion of the whole cutaneous surface. At the same time there were numerous disorders of nutrition evidenced by the formation of an extraordinary amount of fat throughout the body, and there was a high degree of tachycardia. The slightest injury produced nodules like Erythema induratum on the shins, which necrosed and ulcerated in course of time. These lesions seemed in the later stages of her malady to occur spontaneously. Her case was so unusual that I have taken an opportunity of describing it in full (*British Journal of Dermatology*, p. 199, 1902).

After several years of almost complete invalidism she died in March of this year, under unusual circumstances.

On Tuesday, March 17th, she suffered from severe pain in the left breast, which continued all through the night. On the afternoon of March 18th there was no pain, but the whole breast appeared gangrenous and was insensitive to touch. On March 19th the gangrene extended all round the breast, involving almost the whole of the left side of the trunk. She died on March 20th, after four days' illness.

After considerable difficulty I had the opportunity of making an autopsy. The body of the patient was of a deep purple colour, owing to the great congestion of the skin. So marked was this peculiarity that the staining produced by post-mortem lividity on the dependent part of the body was not greater than the cyanosis of the anterior part of the trunk, extremities, and of the face. Extraordinary accumulations of fat existed in the subcutaneous tissue, in the intermuscular septa, the omentum, the subperitoneal tissue, around the heart, and everywhere where fat could be deposited. The muscles were much atrophied, and the organs in the body were also ill-nourished, but no sign of gross organic disease could be observed in any of the viscera. A portion of the skin, which was deeply congested, somewhat elevated above the skin area, and bordering on one of the old scars produced by the lesions resembling

Erythema induratum, was examined by my colleague, Dr. J. M. H. MacLeod. There was found atrophy, and intra- and inter-cellular œdema of the epidermis; the granular layer was absent, the cornification imperfect. Here and there parakeratosis was pronounced, and between the moist horny cells there were layers of leucocytes; the basal layer of the epidermis was unbroken, but the inter-papillary down-growths were flattened out, so that the line between the epidermis and the corium was almost straight. The corium was also markedly œdematous. The lymphatic spaces between the fibrous bundles were widened; the actual fibres had become soft, and in places were split up and swollen; they stained faintly, and here and there had become completely disintegrated. The elastic fibres were also affected in less degree. The most noticeable feature in the corium was the state of the blood-capillaries. These were dilated till in places they had become large cavities lined by several layers of endothelium. The dilatation was marked equally well, both towards the hypoderm and in the subpapillary layer. Associated with the dilated capillaries there was an inflammatory cellular infiltration consisting of leucocytes, connective tissue, as well as a few mast cells. Inflammatory foci and cells were also present round the sweat-coils; the subcutaneous tissue was thickened and less vascular than usual.

This case to which I have alluded, though of a very exaggerated character, is of importance, as it proves as definitely as is possible that the simple erythemata may develop nodular and necrosing lesions, and that these nodular lesions may arise quite apart from tuberculous causation. The serious nature and grave prognosis in the case of this young woman were evident to me from the time I first was consulted about her, not only from what I found on examination, but because I had in my experience the recollection of an important case long under the care of my friend and teacher, Dr. Stephen Mackenzie. Dr. Mackenzie's patient was a young man who also suffered from unusual fatness and permanent congestion of the cutaneous circulation. About three or four years from the commencement of his symptoms he lost flesh, became emaciated, developed a subacute exfoliating dermatitis, and died in much misery. I apprehended something of the same nature in the case of my patient, but the ending was different. After suffering ten or

twelve years, while still abnormally fat, she had acute gangrene of the skin of half the trunk, commencing in the pendulous and deeply congested skin of the left breast, and died in four days.

It is evident, therefore, that severe cases of what we may call simple erythema must be taken as indications of serious disturbance of nutrition, and may be of the gravest prognostic significance.

Exudative Erythema.—It is clear from what I have said that the most simple of the forms of erythema may pass on to true exudative lesions; and in the case of the symptomatic erythemata of contagious diseases it becomes very difficult to decide whether they should be classified as belonging to the simple or the exudative form. The very facts of the pigmentation, which they leave behind, and the desquamation which they are apt to cause, are proofs of a certain amount of exudation. It appears that if the erythema is due to a circulating toxin, a certain degree of exudation in the erythematous lesion becomes almost assured. The presumption that we make at the present time is that the contagious disorders producing erythematous exanthems are in all probability due to bacterial infection.

In Protozoal Infections ; Trypanosomiasis.—But it is interesting to note that protozoal infection is also characterised in addition to the general disorders by erythematous eruptions. Eruptions occurring in the various types of malarial fever have frequently been observed, and of these, irregular forms of erythema are perhaps the most common. Though herpes, urticaria, and petechial eruptions are frequently noted, and even multiple gangrene may occur, no very characteristic form of erythema has yet been identified indicating malarial infection. I presume that it will be doubted by few that the cause of the erythemata in this case is due directly or indirectly to the presence of hæmamoebæ in the blood and tissues.

More recently another disease due to protozoal infection has attracted attention—namely, the serious condition due to infection by species of trypanosoma. Various species of trypanosoma have been identified as the cause of fatal diseases among animals by Lewis, Evans, Lingard, Bruce, and other observers; but it has been recognised only recently that the protozoal organisms of this group may affect the human subject, and a few cases only of patients suffering from trypanosomiasis have been observed in this country. Fortunately I have had the advantage of seeing, with Dr. Manson and

my colleagues at the School of Tropical Medicine, two of these cases. Of one of them a careful record is given in the *British Medical Journal* of March 30th by Dr. Manson and Mr. Daniels. In both these cases a very striking feature of the disease was the skin affection which the patients presented. Both cases showed a very similar eruption. The rash of the disease seems to be more pronounced during the period of invasion, but it appears to be of long duration. There is noticed a slight general œdema of the skin, which is partly subcutaneous, but clearly involves the cutis also, so that the patient presents a peculiarly plump aspect even when a considerable degree of actual emaciation has occurred. On this œdematous skin there is seen a polycyclical erythema, the diameter of the segments of the circles being from half an inch to many inches. The erythema in neither of the cases to which my attention was drawn was bright, but the peculiarly faint, widely spread circinate erythema on the œdematous skin, leaving a certain amount of pigmentation, presented an appearance which is quite unusual in other erythematous diseases. The eruption is general, but appears to affect the back of the trunk and the face in a marked degree.

In these two cases of trypanosomiasis the eruption was so peculiar and distinct from the usual types of Erythema multiforme as to warrant clearly the attribute of an indicator of the disease.

In view of the recent observations of Colonel Bruce and Dr. Castellani on "Sleeping Sickness" in tropical Africa, which point to the occurrence of a trypanosoma in the cerebro-spinal fluid and central nervous system as the cause of the disease, the peculiar irritable, papulo-vesicular eruption which was noted in the cases of the Congo negroes who died of the disease in Charing Cross Hospital, acquires added importance. This eruption may have been the relic of a preceding erythema; and although faint erythematous eruptions on negroes are difficult to see, the possibility of their occurrence during sleeping sickness should be borne in mind by those who have to practise in the tropics.

Evidences of Visceral Disorder and Lesions of the Alimentary Tract.
—Perhaps the most common cause of the forms of blood poisoning which give rise to exudative lesions of the type of Erythema multiforme are the toxins produced as the result of improper food, or of its imperfect digestion or elaboration in the tissues. The indication given

to us by the rapid eruption of urticaria, as the result of bad food or of indigestion, cannot be overlooked in considering the cause of Erythema multiforme. But the amount of clinical evidence at our disposal now, quite apart from the analogy of urticaria, is sufficient to draw particular attention to errors of digestion and metabolism in the causation of exudative erythema. I recollect the case of a girl who used to come to me while I was at the Great Northern Hospital, year after year, suffering from a profuse eruption of exudative erythema with purpuric lesions. During each attack she also suffered from entero-colitis of severe degree, and hæmaturia lasting for some weeks. It was interesting to observe, in addition to the purpuric type of the exudative lesions of the skin, that in the mucous discharge there were usually to be seen points and splashes of blood, giving some indication of what was going on in the bowel. The reason for this serious disturbance of health was that as the autumn came round the girl was taken to the country by her relatives, and as soon as she ate the first blackberries and nuts she suffered from the condition which I have described.

Cases pointing to the same lesson could no doubt be multiplied almost indefinitely. Dr. Osler, amongst others, emphasises the close relationship between the erythema group and serious visceral affections: he quotes cases of severe gastro-intestinal disturbance, with crises of pain of the nature of colic and dilatation of the stomach, presenting eruptions of the type under consideration; and, going further afield, points also to the occurrence of nephritis, attacks of hemiplegia, inflammatory and other complications affecting the lungs, and arthritis of various forms associated with the exudative group of erythemata.

I would refer those interested in this subject to two papers by Dr. Osler, one published in the *American Journal of the Medical Sciences*, December, 1895, and its continuation in the *British Journal of Dermatology*, July, 1900.

As instances of the interesting group of cases which he brings forward in support of the close clinical relationship between the visceral and the cutaneous conditions, I cannot refrain from mentioning the following case synopses given by him:

W. E. B—, colic with urticaria in tenth year. In eleventh year attacks of colic, urticaria with purpura, angio-neurotic œdema,

exudative erythema, enlarged spleen, accompanied by local signs at right apex. In twelfth year colic, enlarged spleen, cough. In thirteenth year colic, cough. In fourteenth year pulmonary symptoms dominant, signs of emphysema. In fifteenth year emphysema well marked, broncho-pneumonia, pericarditis, death.

R. F. B—, attacks of colic every week or ten days for six months. On admission typical lesions of *Erythema exudativum multiforme*, high fever; improvement; recurrence; pains in the joints; arthritis in one joint of finger.

Man aged 57. From tenth year every few months attacks of nausea, vomiting, and abdominal pain associated with outbreaks of urticaria; no hæmorrhages from the mucous membranes; final attack with purpura and urticaria, much vomiting, and profuse and fatal hæmorrhage from the stomach, with blood in the urine and the passage of blood from the bowels.

Man aged 29. When a lad an attack of hemiplegia with aphasia lasting for a week; within a year five or six attacks of transient hemiplegia. History of migraine in 1896, and a mild attack of rheumatism; angio-neurotic œdema of the upper lip. Outbreaks of urticaria in 1897, and attack of abdominal colic, with pains in the legs, and an outbreak of purpura and urticaria. In 1898 hæmaturia and albuminuria.

It seems to be clear that the poisons may be absorbed directly from the intestinal tract, as the result of eating bad food, or elaborated during disordered digestion, when symptoms of intestinal disturbance are almost certain to be present. But as the result of the absorption of certain substances from the bowel which have apparently undergone the ordinary digestive changes, eruptions of exactly similar type may be produced owing to failure of the tissues themselves to deal with them properly. Their further changes in the tissues themselves are disordered. Under the latter circumstances there may be no sign whatever of gastro-intestinal discomfort.

The lesions produced in all such cases are perhaps the most characteristic of the exudative type. They are circinate, even definitely circular; there is effusion of serum, of leucocytes, of red blood-cells. They may be vesicular, bullous, or hæmorrhagic. But it is but rarely possible to find actual infiltration of anything

like the granulomatous type, and scar-formation hardly ever happens. In the cases where scars do follow, the invasion of the lesions by pus-forming organisms must almost necessarily have occurred.

The indications afforded by attacks of exudative erythema, in various forms of poisoning, of the use of drugs, of the administration of the various immunising or antitoxic serums, should be borne in mind, and are capable of much closer definition than they have yet received. As indicators of other forms of disease, such as of the nervous system, *e. g.* in cerebro-spinal meningitis, further observation is necessary before our knowledge can be said to be in any way defined. At the present time I do not wish to touch on these subjects.

Of Renal Disease.—In reference to disease of the kidney a little knowledge is gradually accumulating. On a previous occasion I took the opportunity of pointing out the occurrence of a well-marked circinate erythema in cases of Bright's disease, and quoted the observations made at Charing Cross Hospital by Dr. Lindley Scott on this subject. The inclination for such outbreaks of erythema, apparently in themselves trivial, is to develop desquamative lesions, tending to pass on to exfoliative dermatitis, which has long been recognised as being peculiarly fatal when complicated with Bright's disease.

A few cases have been recorded of wide-spread and severe Erythema multiforme occurring in connection with Bright's disease, and in one recent case the combination of the two conditions produced rapidly fatal results. The probability of a close connection between the disease of the kidney and of a toxæmia producing the cutaneous lesions was forcibly impressed upon those who had the opportunity of seeing this case. If the excretory functions of the kidneys become deficient, and severe affections inhibiting the excretory functions of the skin are also present, it is almost certain that serious results to the sufferer must occur.

In such cases the erythema is acute, symmetrical, wide spread, tends to vesicate or become hæmorrhagic, and involves the visible mucous membranes. In addition the lesions are very liable to become purulent, and the possibility of a terminal pyæmia becomes great. In the case alluded to pyæmia occurred, which was nearly certainly a terminal infection due to the cutaneous lesions.

It is in the forms of exudative erythema, which we have just been considering, that recent observations, and the theories of immunity

founded upon them, allow of a more intelligible interpretation. Whether the toxin is soluble and circulates in the blood, or is the result of the actual presence of parasitic organisms, we know that substances are produced which combine with the blood or the tissue elements, and so bring about destructive changes of which indications are given in transudations, exudations, hæmorrhages, and finally, chronic inflammations. The investigation of a case, say of hæmorrhagic Erythema multiforme, requires to be undertaken from this standpoint, and would probably lead to a great increase of information regarding this group of symptoms, and of the diseases of which they are indications.

Relations of Lupus Erythematosus.—In the case of all the forms of erythema which we have hitherto considered, the nature of the lesions is such that the formation of new fibrous tissue as the mode of healing does not occur, or only to such an extent as not to be appreciable as scar. Scars may occasionally be noted, but they are accidental, and the result of secondary pyogenetic infection. The nature of the exudation and infiltration does not in the first instance destroy the skin nor lend itself to the production of new fibrous tissue. But it has long been recognised that there is a peculiar form of erythema which does produce atrophy of the skin, and the production of scar without ulceration and without infection by pyogenetic influences. It will be obvious that I refer to the disease which is usually known by the peculiarly inappropriate term of Lupus erythematosus.

Much difficulty has been encountered in the study of this disease on account of the superficial position of the granuloma and the symmetrical distribution of the lesion in certain forms of tuberculosis, which closely simulate the localised and more chronic variety of Lupus erythematosus. Many errors in diagnosis have no doubt been made owing to this fact; the superficial tuberculosis, true lupus, has been considered to be Lupus erythematosus. But we are now, I think, in a position to clear this matter up, as the following considerations indicate :

First of all, the histological evidence now at our disposal from examinations of Lupus erythematosus lends no support whatever to the tuberculous theory of its origin. There is none of the arrangement characteristic of tuberculosis in the exuded or newly formed cells,

whereas in the most superficial of the lesions of tuberculosis the structure of the specific granuloma can be made out.

In the next instance tubercle bacilli have never been seen in Lupus erythematosus, nor has the disease when inoculated into animals ever produced experimental tuberculosis; while in the superficial and erythematous forms of tuberculosis, tubercle bacilli may be found and experimental tuberculosis may be obtained. The use of tuberculin sharply discriminates between Lupus erythematosus and tuberculous disease. The reaction is either absent, or occurs apparently only in such cases as also suffer from tuberculosis.

A most important distinguishing element, from the clinical point of view, is the method of onset of the acuter forms of Lupus erythematosus. In these cases there is often wide-spread general erythema of a type which can be distinguished with difficulty from Erythema multiforme; and the atrophy of the skin, which is the characteristic feature of Lupus erythematosus, and which has given rise to a synonym for the disease, is developed only in small portions, though much wider areas have shown erythema. The patches which do scar are those where the erythema remains in a chronic form, and especially where the circulation is terminal, or carried on with difficulty.

The histological examination of the lesions in Lupus erythematosus shows vascular dilatation, exudation of blood-serum and corpuscles, as in cases of Erythema multiforme. But there is in addition a peculiar chronic enlargement of the small vessels and lymph-spaces, which is very characteristic; and still more important, there occurs an infiltration of new cells, some of them no doubt being leucocytes, but others are new connective-tissue cells, and some are the peculiar cuboidal cells well known at the present day as plasma-cells. This infiltration in the upper layer of the cutis, and the peculiar widening of the vessels, are two of the more important distinctions between Lupus erythematosus and Erythema multiforme. Destruction of the connective tissue results, and atrophy of the cutis or an appreciable amount of scar-formation are seen. The nature of the inflammatory process, therefore, must be different from that of exudatory erythema, and yet it is possible that it may be a difference due to the virulence of the poison and the peculiar state of the attacked tissues,—that is to say, a difference of quantity rather than of quality in the poison.

If an opportunity occurs of observing side by side an acute diffuse attack of Lupus erythematosus and a severe diffuse Erythema multiforme, the conditions are so much alike as in many cases to be almost indistinguishable. Two such cases have recently been under my observation.

The case of Erythema multiforme in a young woman was associated with nephritis, and was fatal in three or four months. The case of Lupus erythematosus occurring in a woman of about 35 was associated with cirrhosis of the liver and alcoholism, and proved fatal in three or four years.

It is only by the histological evidence and the clinical course that the distinction can be drawn.

The clinical evidence strongly supports the opinion which is being announced by observer after observer that Lupus erythematosus is a disease which should come into close relationship with Erythema exudativum.

The question arises, can Lupus erythematosus, then, be looked upon as the indication of disease? Or in other words, can its cause be suggested? As I have said, the evidence in favour of its being tuberculosis does not bear looking into. On the other hand, the evidence, as in cases of Erythema exudativum, of its causation by some general process of blood poisoning becomes greater. It will be recollected that when histological and experimental evidence proved that Lupus erythematosus was not tuberculosis, the hypothesis was advanced and upheld with some success that although the disease was not produced by the *Bacillus tuberculosis in loco*, it was in all probability caused by the absorption of poisons from distant or latent foci of tuberculosis. It is not my concern at present to disprove this; these cases may possibly occur, but I think it is clear that they form certainly a small minority. What I am more concerned in stating is that Lupus erythematosus is a peculiar form of exudative erythema, characterised by special lesions of the nature of chronic œdema, and by the appearance of cells in the exudation which have a longer life-period and different functions than ordinary leucocytes. That large areas of the erythema in acute cases may disappear, leaving no visible trace. In the areas of chronic affection, where these cells are especially found, the process of healing is brought about by the production of new fibrous tissue.

The cause of Lupus erythematosus I would therefore regard as a toxæmia, arising from various sources, just as in Erythema multiforme. In the case of Lupus erythematosus, however, there is a strong indication of a second factor besides the vaso-motor disturbance produced by the toxin—namely, the tendency for easily produced paralysis of the vaso-motor mechanism. The sources of origin of these toxins require investigation, and more success is likely to follow our efforts if we throw overboard entirely the suggestion that tuberculosis has any special relationship to the disease.

In the case to which I have alluded—the woman suffering from diffuse Lupus erythematosus,—I remember well the long-continued and futile efforts made to associate her condition with the presence of the tubercle bacillus, while underlying as sources of powerful toxæmia were hepatic cirrhosis and chronic alcoholism. It would appear with strong factors of disease, such as I have mentioned, that the arduous search for a third would *a priori* be fruitless.

A certain amount of evidence also tends to associate Lupus erythematosus with chronic nephritic toxæmia, and from the observation of a few cases I think this point is well worth bearing in mind, especially in the case of middle-aged females, who not unfrequently develop the disease. This association of albuminuria with the acuter variety of Lupus erythematosus has been recently specially emphasised by Drs. Sequeira and Balean. But these are not the only causes of Lupus erythematosus, as the careful work of Dr. Wilfrid Warde on this subject distinctly foreshadows. Underlying the disease, as its cause, are in all probability many forms of blood poisoning in susceptible subjects, of which, perhaps, not the least uncommon is the absorption of the poisons produced by septic (pyogenic) micro-organisms.

I have brought my address to a conclusion with a discussion of what may be considered by some as a very remote indicator of disease, in the hope that the very general and intimate relations of erythematous skin lesions with visceral disease may secure renewed attention.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of the above Society was held on Wednesday, June 10th, 1903, Dr. J. H. STOWERS in the chair.

The following cases and specimen were shown :

Mr. WILLMOTT EVANS showed a case of *Actinomycosis*. The patient was a wood case maker aged 33 years. Three months previously a small swelling appeared in front of the left ear, and grew larger. He was advised to poultice it, and after about a month it was incised. A second swelling appeared below the first, and was also opened, and later an incision was made below the eyes. When seen there was a general but nodular swelling of the left side of the face, extending from the lower eyelid to below the lower jaw, and from the ear nearly to the nose. The swelling was, on the whole, hard, but it had softened in places. There were three apertures, which had been made by incision, and from these protruded fungating granulations, and by pressure a purulent liquid could be made to exude from them. In this discharge bright yellow spots were visible, and by the microscope the actinomyces could be seen. The mass apparently involved the masseter muscle, and had infected the skin secondarily. There was a carious tooth on the left side, but no evidence of involvement of either jaw. The treatment that was intended to be adopted was scraping with a sharp spoon, and the administration of large doses of potassium iodide. There was nothing in the history to suggest the mode of infection.

Dr. COLCOTT FOX exhibited (1) a bricklayer, Charles G—, aged 28 years, who had contracted gonorrhœa four weeks previously, and was suffering from inflammation of the left wrist-joint. An eruption appeared suddenly two weeks ago, but had not extended beyond the areas originally involved. The patient was not taking medicine prior to the evolution of the eruption. The lesions consisted of small congestive papules of a lively red colour, $\frac{1}{16}$ to $\frac{1}{8}$ inch in diameter, thickly scattered over the whole abdomen and lower half of the trunk behind. They became capped with a tiny central vesicle. At the present time the colour of the papules has dulled in tint, and is

not unlike that of syphilides. The vesicles have dried into little thin crusts, which can be easily removed, disclosing a red congestive macule, without evidence of cellular infiltration. Some of the lesions are grouped in pairs or in rows.

Dr. Fox said his colleague Mr. Arthur Evans had sent the case to him for a diagnosis, but he was at a loss to give one. The influence of drugs could be excluded. The absence of infiltration put a papular syphilide out of court. There was a certain superficial resemblance to an acute follicular psoriasis, but the evolution as an acute erythematous-vesicular rash, and the formation of crusts as distinct from scales, and the distribution, seemed to put that out of court. Could it be due to gonococcic invasion? Unfortunately the exhibitor did not see the case in the vesicular stage, when the contents might have been investigated for the gonococcus. A considerable literature now exists on gonococchæmic eruptions; but, apart from the keratotic conditions, these are mostly of the erythematous type. Paulsen, however, has recorded cases in new-born infants in whom a small-patterned papulo-vesicular eruption developed containing gonococci. In a case of Besnier's there was an intense generalised erythema, with some miliary vesicles. Since showing the case all the miniature crusts have spontaneously fallen, leaving red macules, as in *Impetigo contagiosa*.

(2) A woman over 70 years of age with an eruption which he diagnosed as *Lupus erythematosus*. She was sent to him a few weeks ago for a diffuse eruption of the scalp, chiefly of the vertex, of uncertain duration. The eruption had left atrophy, but around many follicles an intense congestion was present, as so often seen in *Lupus erythematosus* of the scalp, and this feature was very marked in a patch on the forehead at the border of the hair. The patient was ordered gr. xv of salicin thrice daily, and locally a zinc cream. After a week the patient suffered from an acute outburst of erythematous blotches indistinguishable from *Erythema multiforme*. The blotches became confluent, and the scalp, face, ears, neck, and upper half of the trunk and shoulders were quickly covered in a diffuse congested sheet. The patient was not ill. The decline of this eruption was marked by free desquamation, and the whole attack was acute. At the present time it is interesting to note that the scalp presents only atrophy. The forehead has fairly well marked patches

of Lupus erythematosus, and new areas have been left on the bridge of the nose, and symmetrically in the centre of each cheek, and in front of the ears. These did not exist before the acute outburst, and they are simply congestive in appearance and at present without signs of atrophy.

Dr. Fox had ordered salicin to be resumed to watch its effect, as the drug had been discontinued on the appearance of the acute outburst. Whether the outburst was of the nature of a medicinal eruption or an acute Lupus erythematosus was doubtful.

Dr. GALLOWAY brought forward a man aged about 50 years, who had suffered for twelve months from a chronic inflammatory eruption producing a severe degree of lichenification of the whole cutaneous surface. Throughout the illness there had been almost no oozing from the surface, while there appeared to be in certain places, such as the anterior surface of the shins and ankles, an excessive hyperkeratosis.

The diagnosis between an abnormal form of lichen ruber or an exceedingly chronic eczema with papular lesions was very difficult, and a definite opinion was difficult to form. On the whole the opinion of the exhibitor and others was in favour of an abnormal lichen ruber.

The man, since the date of the meeting, had been an in-patient under the immediate observation of Dr. Galloway, and the further development of the case tends to show that after all the condition is of the eczematous type, with extraordinary lichenification and exaggerated parakeratosis.

Dr. GRAHAM LITTLE showed (1) a *seborrhoïde* of the face, which he considered to be of the same type as the eruption in a case exhibited and described very fully and completely, with illustrations, by Dr. Pringle in the February number of this Journal. Dr. Little had had numerous opportunities of watching Dr. Pringle's case both before and after it was shown to the Society, and he was convinced that the case now shown was of the same character. The patient was a young woman aged 25, and her home was in the country. She enjoyed excellent general health, and though she was liable to flush after taking hot tea, did not suffer from indigestion. She had been

troubled with this condition of the skin for the past two years, with exacerbations and remissions during that time, but the present attack had lasted with little change for about six months. When shown she had the following appearance :—The face was universally red, with permanent flush, and on the reddened surface there were numerous small follicular-looking papules, thickly studded together, especially on the cheeks, the chin, and the forehead. There were also several small papules of the same kind, but without the underlying redness, appearing on the neck below the ears and chin. There were a few papules on the nose, and this was not markedly reddened, but it was distinctly seborrhoic in aspect, with shiny moist skin; and the same condition was noted in the conchæ of the ears, where minute drops of moisture were visible. The papules were mostly of the same size, about a millimetre in diameter, in only a few instances exceeding this. The skin between them, besides being reddened, was also distinctly scaly, with a fine desquamation, especially marked on the cheeks. There was no comedo-formation, and there was no suppuration in any of the papules. There were no telangiectases. The rosaceous element was not so prominent as in Pringle's case, and the papules were on the whole somewhat smaller. A biopsy was unfortunately unobtainable.

Dr. PRINGLE accepted without reservation the view of the essential similarity of this case to his own, described, as above stated, in the Journal. Dr. COLCOTT FOX was also understood to concur in this opinion.

Note by Dr. LITTLE.—The cases of this disease already recorded are sufficiently numerous and are sufficiently distinguishable, as well by their similarity to one another as by their dissimilarity to other affections, to warrant their separate grouping; and it seems desirable to name the disease, if only provisionally, for the convenience of reference. Besides the present case and the cases mentioned by Pringle in his paper, quoted above, Dr. Brooke, of Manchester, has had at least three cases which he is to describe in a forthcoming paper in the Journal. I had the advantage of working out the histological appearances of the lesions in Pringle's case, and I have been favoured with sections from Brooke's as yet unpublished cases. They are all so alike as to leave no room for doubt as to their pathological identity, and their clinical resemblances were even more strikingly obvious.

(2) A case of *grouped comedones* in an infant. The patient is a male child aged 15 months, and is healthy in other respects. Immediately below the clavicles on either side there is a group of

typical comedones, the majority of them being inflamed, and some of them suppurating. Each group consists of about thirty to fifty lesions of this character, and there are sporadic lesions of the same kind on the summits of the shoulders and on the back just above the spine of the scapulæ. The condition has persisted for three months, and is dated by the mother from an attack of bronchitis, in which she used camphorated oil to rub the child's chest. But the oil was used over far wider areas than are occupied by the disease, and no oil or any other local application has been used for the past three months, yet there has been no subsidence of the lesions. Moreover, in the cases reported by Fox, by Crocker, by Julius Cæsar, and others (in most of which, however, the comedones were on the face), there was a marked predominance of male over female infants as subjects of this disease, the proportions being three fourths males to one fourth females. From all these arguments it seems certain that some other cause besides local irritation must be invoked.

(3) A case for diagnosis. The patient was a woman aged 36. She had a bright red, slightly infiltrated patch of sharply demarcated erythema, some three inches by two and a half in extent, situated on the flexor aspect of the lower right forearm; and she gave the history that this patch had persisted *in statu quo* for three years, not enlarging or changing very much except that it was redder at times than others, and that the irritation, which was fairly constant, increased as the redness grew deeper. There were no indications of disease of the skin in other parts. When she was first seen the redness was livid (and, according to the statement of the patient, it frequently becomes purple), and the patch was distinctly raised and infiltrated. The patient was a stout woman, apparently in good health; there was no œdema of the arms or elsewhere.

(4) A case of *Urticaria pigmentosa nodularis*, previously shown at the meeting of the Society in October, when the child had a copious eruption of large pigmented nodules; and a picture of the state at that time was shown for comparison with the present condition. The nodules had almost all become flattened to the level of the skin, the pigmentation remaining unchanged. The child had been under observation all the time, and the substitution of the macular for the markedly nodular type of the disease seemed to be attributable to an intercurrent attack of measles, after which the change had become

very pronounced. This had happened some months ago, and the earlier lesions had remained macular; but fresh lesions (nodules) were appearing.

Mr. GEORGE PERNET showed a case of a girl aged 24, who had been attending at University College Hospital under Dr. Radcliffe-Crocker. She had cribriform pitted scars crowded together in patches on the cheeks and between the brows. These appeared to have arisen from indolent millet-seed pustules, the base of which was a brownish red, while the pustular portion was not larger than a pin's point. The patient stated that the pitting was the result of the previous lesions of the disease, which had been going on from the age of 15 years. Several cases of cribriform pitting had been exhibited at the Society by Drs. Radcliffe-Crocker, Colcott Fox, and others, and it was suggested that they were probably due to a similar condition as the present case, and that it was perhaps only a variant of the disease known as *Acne agminata*, or the *acnitis* of Barthélemy. The patient also had small pustules scattered about the face, and also on the frontal border of the scalp, some being even present in the scalp itself near the boundary line.

Dr. WHITFIELD showed a man aged 22 years suffering from *Keratoma palmare et plantare*. There was no history of this or any other skin affection in his family. The thickness of the skin of the palms and soles was noticed at birth, and became progressively more marked as he grew older. Some two or three years ago he had gone to work filling the cylinders of the railway carriages with gas, and he noticed that there was always some irritating liquid leaking away from the joints of the pipes, and this made his hands much worse. He had now for some time given up this employment, and consequently his hands were not quite so bad as formerly. The horny layer of both palms was enormously thickened, forming a semi-transparent, yellowish pad covering the whole palms and extending for about a quarter of an inch round the sides of the fingers and the ulnar margin. There were deep fissures scattered about over the surface, but they did not seem to correspond with the ordinary creases of the palm, nor did they extend right through the enormously hyperplastic horny layer. The nails were practically

normal, and the horny thickening did not extend under the nail-plate to any noticeable degree. The soles showed a somewhat similar condition, but the part covering the arch of the foot showed scarcely any thickening, so that it was evident that the hypertrophy was partly dependent on pressure and friction. The attempt was going to be made to get the condition under control with continued use of salicylic acid. Unna had reported the cure of some cases by this method. All the members who had any experience of such cases stated that their opinion was that it was useless to expect permanent cure, and it was pointed out that no evidence had been given of the duration of the cure in Unna's cases.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

THE Annual Meeting and Conference of this Society was held on Wednesday, May 27th, Dr. Stowers, the President, in the Chair.

The Report of the Council was read, and gave rise to a considerable discussion, especially the paragraph containing the recommendation of the Council, viz. "That the *Transactions* be no longer published."

It was proposed and seconded that the Report be adopted ; when Dr. Abraham moved the following amendment, which was seconded by Dr. Savill, viz. :—"That the question of the future non-publication of the *Transactions* be referred to the incoming Council for further consideration."

Nine members voted for and twelve against the amendment.

The Report of the Council was then put to the meeting.

Eleven members voted for and seven against. Several members abstained from voting.

The Treasurer's statement having been passed, the ballot for officers for the session 1903-4 took place, and resulted in the following gentlemen being elected :

PRESIDENT.—J. H. Stowers, M.D.

PRESIDENT-ELECT.—H. Waldo, M.D.

VICE-PRESIDENTS.—P. S. Abraham, M.D. ; R. L. Bowles, M.D. ;

Jas. Galloway, M.D.; A. J. Harrison, M.B., J.P.; J. F. Payne, M.D.; H. H. Phillips-Conn, M.D.; P. H. Pye-Smith, M.D.

TREASURER.—C. H. Thompson, M.D.

HON. SECRETARIES.—Arthur Shillitoe, F.R.C.S.; Wilfrid B. Warde, M.D.

COUNCIL.—Wallace Beatty, M.D.; H. A. G. Brooke, M.B.; Sir Alfred Cooper, F.R.C.S.; H. Radcliffe-Crocker, M.D.; A. Eddowes, M.D.; Willmott Evans, F.R.C.S.; W. T. Freeman, M.D.; A. J. Hall, M.D.; E. Graham-Little, M.D.; Geo. Pernet, M.R.C.S.; Geo. W. Sequeira, M.R.C.S.; Ed. Stainer, M.D.

The PRESIDENT then called upon Dr. Corlett, Professor of Dermatology and Syphilology in the Western Reserve University, Cleveland, Ohio, to deliver his address on "The Present Epidemic of Smallpox throughout the United States, together with a short consideration of the different Types of the Disease, their Recognition, and some of the Influences of Vaccination; illustrated by lantern slides."

The address will be published *in extenso* in a future issue of the Journal.

Photographs of interesting cases were exhibited by the President, Dr. Harrison, Dr. Abraham, and Dr. Freeman, together with the coloured drawings which had been added to the Society's album during the year.

Dr. ALFRED EDDOWES showed a coloured drawing of three so-called "veldt sores" contracted by a soldier during the South African campaign. Sections under the microscope proved the cause to be an endo-tricophyton.

The "sores" were raised, dry, and scaly.

HISTOLOGICAL NOTE.

"ON THE BIOLOGICAL RELATION BETWEEN THE EPIDERMIS AND THE CONNECTIVE TISSUE" (KROMAYER).

BY J. H. M. MACLEOD.

THE position which Kromayer has taken up with regard to the biological relation between the epidermis and the connective tissue

is as interesting as it is revolutionary. Within recent years we have come to expect from the dermatologist of Halle a definite, though sometimes isolated opinion on matters of histological import. In a long paper in the *Archiv f. Dermat. u. Syph.*, October, 1902, p. 299, he definitely states his position; and if the theories so strongly advocated in that contribution be confirmed and accepted they will go far to upset many of the prevalent ideas both in embryology and in pathology. On this account it is advisable to examine them somewhat critically.

The question at issue is the developmental relation of the epidermis to the corium, a subject which has of late years been almost as fruitful in controversy as the somewhat wearisome polemic on the origin of plasma-cells. The theory which Unna propounded with regard to the cells which form the infiltration in the corium in soft moles—a theory which was recently corroborated by Whitfield in a convincing paper, based on photo-micrographs, on the origin of nævus-cells,—namely, that the nævus-cells are derived from the epidermis and have got cut off from it and deposited in the corium, is now accepted by many histologists. Kromayer, who originally strongly opposed this view, became a convert to it and went to the other extreme, and asserted that not only could epithelial cells be deposited in the corium, but that they could evolve into connective tissue; and he now asserts that the corium is in reality derived from the epidermis,—in other words, that the basal layer of the epidermis, which is the mother-layer, not only gives origin to the overlying Malpighian and horny layers, but also to the subjacent cellular and fibrous elements of the corium. This view he bases on a large series of photo-micrographs of sections of skin, thirty of which are reproduced in the monograph above referred to. The sections are of skin from different parts of the body of a youth aged 16, and a girl aged 10; there are also several photographs of nævi. As space will only permit a brief recapitulation and criticism of the various headings and conclusions in Kromayer's monograph, the reader who is interested in the subject is strongly recommended to carefully study the original.

At the outset a new histological term is introduced—namely, “desmoplasie.” The evolution of epithelial cells into connective-tissue cells he designates as “desmoplasie,” and the type of cell

which he regards as common to both layers, or the connecting link or bond (δεσμός) between them, he christens a "desmoplastic cell."

The first proposition he discusses is the already accepted one that cells may become cut off from the epidermis and deposited in the corium, and cites the nævus-cells in proof of it, but makes the assertion that it may occur not only in abnormal conditions such as soft moles, but also in the healthy skin. He asserts that this process "begins with a swelling of the protoplasm of the epithelial cells and a loss of their fibrillary structure, and a shrivelling of the nuclei, which become richer in chromatin and are gradually displaced towards the periphery of the cell. The protoplasm of the cell now assumes a spongy appearance, and the type of cell known as a vesicular cell results (Bläschenzellen). These vesicular cells then become deposited in the corium." Waldeyer years ago described cells in the corium which corresponded closely to the "vesicular cells" of Kromayer, and called them "plasma-cells," including under the same heading the mast-cells. These cells are different from the "plasma-cells" of Unna, and are not pathological. They were subsequently described by Schäfer as "vacuolated cells," and they can generally be detected in the corium; but there is no definite proof that they take their origin in the epidermis, but rather that they are a type of connective-tissue cell, and they differ markedly from the cells present in the corium in soft moles. They may be detected in the corium of the embryo of the rat when the epidermis consists of a single row of palisade cells covered by the epitrichium, and no developmental relation can be traced between them and the epidermis.

Of course it may be objected that Kromayer's vesicular cells are different from the vacuolated cells of the corium, in which case they are something which has not up to the present been recognised in a field of histology which has been well worked out by Waldeyer, Klein, Schäfer, and a number of other eminent histologists. Still this is by no means a convincing argument against their existence.

Kromayer's second proposition is that the vesicular cells form connective-tissue fibres, and he describes the process of evolution as follows:—"The fibrous change begins at the periphery of the cell, in which region the protoplasm becomes changed into connective-tissue fibrils which enclose the cell like a basket. At the same time the vesicular protoplasm disappears, and the nucleus becomes

small and elongated and assumes the appearance of an ordinary connective-tissue nucleus." Kromayer thus supports the view that the white fibrous elements are developed from the connective-tissue cells directly by a transformation of the protoplasm into collagen fibrils, in opposition to the theory that they are deposited in a structureless intercellular substance, the so-called indirect origin of the connective tissue. The hypothesis that the cells from which they develop are the vesicular cells and not the ordinary connective-tissue cells is an unusual one. In embryonic connective tissue and in granulation tissue all stages can be traced between the small roundish connective-tissue cell or fibroblast, through the spindle-cell, to the connective-tissue bundle, but although vacuolated cells are present they seem to play no part in this change. They are undifferentiated cells in which mitotic figures may be detected, and whose function seems to be that of reproduction rather than that of differentiation into fibrous elements. There is very strong evidence in favour of regarding them as the mother-cells of the corium, and as bearing the same relation to the corium as the cells of the basal layer bear to the epidermis. The cells of the basal layer never become differentiated into prickle-cells and horn-cells, but their daughter-cells do; and in the same way the vacuolated cells do not seem to develop into fibrous elements, but their daughter-cells, the fibroblasts, are capable of doing so.

He further states that these vesicular cells have originated in the epidermis, but have lost their peculiar epidermal characteristics by assuming connective-tissue peculiarities; and believes that this power of metamorphosis, or "desmoplasie," is a common property of all epithelial cells, and may occur in a marked degree in the mucous membrane of the mouth, œsophagus, and stomach, and also in the epithelium of the internal organs, such as the liver, kidneys, and lungs, as well as in the epidermis. As a corollary to this statement Kromayer asserts that the corium originates in the epidermis, and that it is developed in its entire thickness by a deposition of cells from the overlying basal layer.

The evolution of a single "desmoplastic cell" is said to occupy weeks or months. On account of this supposed developmental relation he includes the epidermis and corium together as a single organ, which he names the "parenchyma of the skin," the matrix of

which is the basal or germinal layer of the epidermis. New growths of the skin should thus be considered as affecting the whole of the skin at once, and only differing from one another in what he calls the "degree of desmoplasie;" and many of the atrophic and hypertrophic states should be regarded simply as examples of "hypo- and hyper-desmoplasie," and any anomalous condition in which the process of evolution of the desmoplastic cell is imperfect, as a "para-desmoplasie." Sarcomata and granulomata would thus differ from epitheliomata, not in being derived from different embryonic layers, but in taking their origin from cells of a single layer in different states of "desmoplasie."

It is impossible to treat a hypothesis such as this one without the greatest respect, however far-fetched it may seem, since it comes from the pen of so distinguished a histologist as Kromayer; still it is far from being convincing. Granted that the "vesicular or desmoplastic cells" are something new, and not the same as the "vacuolated cells" of Schäfer, that assumption might allow of the possibility of their development into a fibrous bundle; but it does not in any way prove that they are developed from the epidermis. If this hypothesis were carried to its ultimate issue it would ask us to believe that the distinction of the epiblastic and mesoblastic layers of the blastodermic vesicle is valueless. Certainly, if we go far enough back, both layers are developed from an undifferentiated ovum; but early in embryonic life a differentiation takes place into these embryonic layers, and once this differentiation has occurred there is every reason to believe that the growth of these layers takes place by the reproduction of cells belonging to one or other of them. This revolutionary hypothesis is based on certain appearances in sections of healthy skin, which are reproduced in the photographs illustrating the paper. These show cells here and there in the epidermis which have a vesicular appearance, and somewhat similar cells in the corium near the basal layer. Vesicular cells, not unlike those represented by Kromayer in the epidermis, I have seen in the epidermis from time to time in pathological conditions in which oedema was present; and cells similar to the vesicular cells I have frequently noted in the healthy corium, and these I believed to be the vacuolated cells of healthy connective tissue. As the subject of the evolution of the cellular and fibrous elements of the connective

tissue is by no means fully understood, Kromayer's hypothesis may have the valuable effect of stimulating further research upon it; but to find the solution of it in the hypothesis that they are derived from the basal layer of the epidermis seems to me to carry almost as little conviction as to assert from the same appearances and premises that the corium was the mother-layer, and gave origin to the epidermis.

CURRENT LITERATURE.

THE ETIOLOGY OF ACNE VULGARIS. GILCHRIST. (*Journ. of Cut. Dis. including Syph.*, March, 1903.)

PROF. GILCHRIST publishes the results obtained in his continued researches on the *Etiology of Acne vulgaris*. After a survey of the investigations of Unna, Hodara, Lomry, Sabouraud in 1894 and 1902, Bollack and his own in 1899, Gilchrist states that he has found definite bacilli, which he named in 1899 *Bacillus acnes*, in all smears taken from 240 typical acne lesions from eighty-six patients; that pure cultures were obtained from sixty-two lesions (chiefly acne nodules) from twenty-nine patients, eighty-two cultures being sterile from use of an improper medium, and the remainder being contaminated by *Staphylococcus pyogenes* or *epidermidis albus*, or the latter growth alone; that the bacillus is found deep down in *Acne indurata*; that he has proved *Bacillus acnes* to be pathogenic in mice and guinea-pigs; and finally, that he has demonstrated that the blood-serum of acne patients agglutinates these bacilli. For these reasons he holds he has definitely proved that his *Bacillus acnes*, which he was the first to obtain in pure culture from acne lesions, is the primary cause of *Acne vulgaris*.

Gilchrist gives an interesting exposition of the stages of the disease from an examination of a comedo, an early acne papule, a pustule, and five acne nodules. The comedo is formed by a hyperkeratosis of the inner layer of the dilated hair-follicle, and these changes are accompanied by some dilatation of surrounding blood-vessels, but without inflammatory reaction. In the papule the lower part of the greatly distended follicle is surrounded by a mass of polynuclear leucocytes and nuclear detritus. Sections of the nodules showed quite profound changes extending deep into the corium, surrounding in some nodules a magnified and markedly hypertrophied follicle. The lesion was made up of masses of cells, many giant-cells, plasma-cells, which were very numerous in some nodules, but replaced in others by lymphoid or connective-tissue cells. Further, many polymorphonuclear cells were present, and massed in some sections to form miliary abscesses; also phagocytes and pigment cells. Some of the giant-cells contained bacilli.

Gilchrist has seen a pure culture of Sabouraud's micro-bacillus of *Seborrhœa oleosa*, and says to the eye it resembles his *Bacillus acnes*; but Sabouraud thinks the inflammatory lesions of *Acne vulgaris* are caused by a secondary infection of the comedo.

Lastly, Gilchrist suggests that the constitutional and other symptoms often found associated with *Acne vulgaris* may be due to a poisoning with toxins of the *Bacillus acnes*.

T. C. F.

REPORT OF A CASE OF SYSTEMIC BLASTOMYCOSIS WITH MULTIPLE CUTANEOUS AND SUBCUTANEOUS LESIONS.

OLIVER S. ORMSBY and H. H. MILLER (from the Laboratory of Drs. Hyde and Montgomery). (*Journ. of Cut. Dis., including Syph.*, March, 1903.)

ORMSBY and Miller, of Chicago, have very carefully investigated a most interesting fatal case of Systemic Blastomycosis which was observed in the person of a Swede, aged 56, who was a patient in the Battle Creek Sanatorium. The authors give the following *résumé* and conclusions:—(1) The first evidence of the illness which ended fatally in this case was exhibited in the lungs. (2) Early general toxæmia was present, as evidenced by fever, weakness, emaciation, etc. (3) The cutaneous manifestations began two months after the initial illness, and were manifestly of internal origin, coming by way of the circulation. (4) These lesions comprised subcutaneous and cutaneous nodules and abscesses, open and discharging or crust-covered ulcers, and were extensively distributed, being, as a rule, smaller about the head and face and larger on the extremities. The trunk had comparatively few. (5) Pure cultures of blastomycetes were obtained from the subcutaneous abscesses before death, and from various tissues and internal organs post mortem. (6) Microscopic examination of both the internal and external lesions and the sputum failed to show any tubercle bacilli, but all showed enormous numbers of blastomycetes. (7) Animal experiments were negative as to tuberculosis. (8) Tuberculin reaction was negative. (9) Post-mortem examination revealed lungs riddled with miliary abscesses and tubercle-like lesions, the pleura studded with nodules, the liver extensively filled with miliary abscesses and tubercle-like nodules. The kidney was similarly affected, but not so extensively. The spleen was markedly affected, some portions being practically destroyed. The mesentery was studded with nodules. In all these situations blastomycetes were demonstrated microscopically and culturally, but tubercle bacilli were found in none. (10) The early lung involvement and other symptoms, the laryngitis, the microscopic appearance of the organs, and the patient's family history all suggested tuberculosis. (11) The absence of the tubercle bacillus, culturally, microscopically, and experimentally, the negative tuberculin reaction, the absence of the usual microscopic tubercular architecture, the failure to reproduce tuberculosis in animals, the extraordinary number and rapid evolution of the cutaneous lesions, and lastly, the abundance of the blastomycetes in every lesion, rule out tuberculosis.

This well-observed case is abundantly illustrated by excellent photographs.

T. C. F.

THE LIGHT TREATMENT IN LUPUS AND OTHER DISEASES OF THE SKIN. MORRIS and DORE. (*The Practitioner*, April, 1903, p. 433.)

IN the beginning of this well-illustrated paper the writers tabulate the physical principles on which Finsen's method of treating lupus and other diseases of the skin by means of the chemical rays of light is based—namely, the properties of

light to stimulate organic life, to cause an inflammatory reaction of the skin, to destroy bacteria, to penetrate the skin, and to produce pigmentation. They then compare their results with those of Finsen, which, "though not so brilliant as those claimed by Finsen, have been satisfactory in a considerable number of the cases." Out of sixty-five cases of Lupus vulgaris treated, eleven have remained without relapse for periods varying from six months to two years, and in ten of these the recovery has been complete. In fifteen cases slight relapses have occurred. Fifteen cases are still under treatment.

Of eleven cases of Lupus erythematosus, great improvement has taken place in seven, and of twenty-seven cases of rodent ulcer, favourable results have been obtained in twelve.

The authors wisely protest against the loose employment of the terms "light treatment" and "Finsen" treatment by many writers, and point out that the term "light treatment" should be reserved for treatment with the chemical rays—namely, the blue, visible violet, and ultra-violet,—and should not be made to include that by the X rays.

Their observations agree with those of most workers—that the smaller lamps such as those of Bang and Miller, are too superficial in their action to be of value. With regard to high-frequency currents, the authors state their belief that in dermatological practice nothing can be done by these currents which cannot be more effectively compassed by the Finsen light and X rays.

The paper concludes with short descriptions of six cases treated by Finsen light and X rays, illustrated by reproductions of photographs taken before and after treatment.

J. M. H. M.

ON AN URTICARIAL SKIN AFFECTION. HARTMANN. (*Archiv f. Dermat. u. Syph.*, March, 1903, lxiv, p. 381.)

In this contribution the writer describes seven cases of what is usually named "Urticaria perstans." The majority of these cases occurred in the dermatological clinic of Dr. Herscheimer, at Frankfurt. The leading symptoms present in these cases were itching, and a papular eruption with excoriations. The papules were rounded, indurated, reddish or reddish blue in colour, and varied in size from a lentil to a ten-pfennig piece. The surface of the papules was smooth and sometimes shiny. Numbers of them were capped by a hæmorrhagic crust from scratching. In one of the cases the surface of the lesion was verrucose (*Urticaria perstans verrucosa*). The eruption was widely distributed, but left the palms, soles, and scalp free, and as a rule the face was little affected. The itching seemed to precede the papular eruption, and sometimes had existed for several years before the first papule appeared. The itching was not as a rule universal at first, but began on one of the extremities. In none of the cases was there any evidence that the lesions had begun as ordinary wheals. It is a disease of adults, and begins usually after the patient has reached the age of 20; it seems to be equally common in either sex. The condition differs from the Prurigo of Hebra in that the lesions are larger and fewer, and in that it affects the flexor aspects of the joints and limbs. A histological examination of two of the cases showed chronic inflammatory changes in the skin, a cellular infiltration in the corium around the blood-vessels, glands and in the papule, and a diminution of the elastic fibre. The epidermis

was secondarily affected, the prickle-cell layer being thickened, and there was hyperkeratosis of the horny layer in some places and parakeratosis in others. After discussing the literature at considerable length, the writer concludes that we have to deal in this affection with a chronic pruritus associated with a papular or verrucose eruption which is secondary, and is probably the result of mechanical irritation.

J. M. H. M.

A CASE OF WIDELY DISTRIBUTED SWEAT-GLAND ADENOMA WITH CYSTIC FORMATION. THEODOR BRAUNS. (*Archiv f. Dermat. u. Syph.*, March, 1903, Bd. lxiv, p. 347. Three plates.)

THE subject of this affection was a man aged 45 years, who presented on the trunk, especially on the breast, abdomen and inguinal regions, a large number of tumours, varying in size from a hemp-seed to a hazel-nut. These tumours were irregularly distributed; they were soft to the touch, and were the colour of the normal skin. On cutting into the lesions it was found that they were cystic and took their origin near the subcutaneous tissue. They contained a yellowish pulpy mass.

A histological examination showed that the tumours were due to adenomata of the sweat-apparatus, which had become cystic, and, although the cause of the cystic formation was not proved, the microscopical appearances suggested that they were retention cysts due to a blocking of the canal by dead epithelial cells and *débris*. A reference was made to the literature of the subject, and the cases of Török, Bartel, Elliot, Perry, and Rolleston were referred to.

J. M. H. M.

ON WHITE ATROPHIC SCAR-LIKE PERIFOLLICULAR MACULES ON THE SKIN OF THE TRUNK. W. W. IWANOW. (*Arch. f. Dermat. u. Syph.*, March, 1903, Bd. lxiv, p. 369.)

IN a large number of adults, if the skin of the trunk, especially that between the shoulders and in the presternal region, be examined, a greater or less number of white atrophic spots can generally be detected. These lesions are always sharply circumscribed. They are sometimes raised above the level of the surrounding skin, at other times they have the same level, and occasionally they are slightly depressed. They are generally round or oval in shape. In the centre of them there are usually one or more openings of follicles, and sometimes hairs may be present in them, and more rarely a comedo-plug. These lesions are simply acne scars. In them there is atrophy both of the papillary body and the corium, which, after the disappearance of the inflammatory disturbance, assumes a more or less atrophic form. Occasionally small keloids develop instead of these flat scars; but why keloids should appear in some cases and not in others the author is not prepared to say, except to assert, with others, that there is an idiosyncrasy towards their formation in certain individuals and not in others. Goldmann, who has studied this question, states that if the elastic tissue does not regenerate a keloid forms, while if it does a flat scar is produced.

J. M. H. M.

PEMPHIGUS VEGETANS. HAMBURGER and RUBEL. (*Johns Hopkins Hosp. Bull.*, April, 1903, p. 63.)

CASES of this variety of chronic pemphigus, first described by Neumann in 1886, are sufficiently rare to merit a careful study. After discussing the literature on the subject at considerable length, the writers describe a case of this unusual disease. Like Waelsch, they isolated a pseudo-diphtheria bacillus from their case, but were unable to prove a causal relation between it and the disease, or to establish *P. vegetans* in the category of the infectious diseases. The patient was a farmer aged 52 years. In this connection it is interesting to note that Hutchinson, Danlos, Hudelo, and Brocq have all noted the occurrence of the disease in the country, and have commented on the fact. The affection began as usual in the mucosa of the mouth, where "blisters" appeared, which were soon replaced by ulcers. It then spread to the groin, where it was at first mistaken for eczema. From there it spread to other regions of the body, till, with the exception of the palms, soles and scalp, no part of the skin was entirely free from lesions. The lesions began as vesicles or bullæ, varying in size from a lentil to a thumb-nail. The bullæ were flaccid, discrete, and the skin about them was unchanged. When they broke, bright red weeping excoriations were left, the border of which was formed by a ledge of epidermis. Some of the excoriations were covered with impetiginous crusts, and were surrounded by a red halo. Scattered among these lesions were tiny papulo-pustules due to secondary inoculation. In the groins there were elevated, foul-smelling excrescences, about 10 to 20 cm. in diameter. The surface of these lesions was crusted and cracked; closer inspection revealed its papillary character. The nails of the left hand presented deep transverse ridges.

The patient was given liquid food, and $\text{m} \cdot \text{vj}$ of Fowler's solution was prescribed three times a day. This caused a temporary improvement, but fresh lesions appeared from time to time. The temperature was elevated and irregular, ranging as a rule from 99° F. to 99.7° F., only on two occasions going above 102° F. The patient lost weight continually, became much emaciated, signs of broncho-pneumonia developed, and he died after an illness of about fourteen months. At the autopsy, with the exception of the skin and the lungs, all the organs were found to be healthy, and there was no ulceration in the gastrointestinal tract or in the bladder.

J. M. H. M.

THE HISTOLOGY OF KERATOSIS PILARIS. S. GIOVANNINI. (*Archiv f. Dermat. u. Syph.*, December, 1902, p. 163. Five Plates.)

THE material for the histological examination on which this paper is based was obtained from twenty-five cases of Keratosis pilaris (Lichen pilaris). In some of the cases there was no inflammation associated with the keratosis of the follicles, while in others an inflammatory disturbance was a marked feature. Pieces of normal skin were also excised in several of the cases for the purpose of comparison. Where inflammatory changes were absent the most noticeable of the abnormal features in the histological picture was a marked widening and deepening of the funnel of the hair-follicle. This was filled with a horny plug in which were coiled up one or more hairs, more or less split up into fibres. The hyperkeratosis was not confined to the follicular mouth, but affected the surrounding

epidermis. The prickle-cell layer (outer root-sheath) of the mouth of the follicle was markedly atrophic. Atrophic changes were also present in the sebaceous glands and arrectores pilorum, and several of the follicles themselves were destroyed. Where inflammatory changes were present the vessels around the hair-follicles were dilated, and there was a small-celled infiltration.

J. M. H. M.

SARCOMA IDIOPATHICUM MULTIPLEX EN PLAQUES PIGMENTOSUM ET LYMPHANGIECTODES. R. BERNHARDT.
(*Archiv f. Dermat. u. Syph.*, December, 1902. Two plates.)

IN this contribution the writer describes the case of a patient, aged 26 years, suffering from a condition of the skin which closely resembled, but did not seem to be identical with, Sarcoma idiopathicum multiplex of Kaposi. In this case it began on the left lower extremity. Seven years before he had an attack of erysipelas of that leg, which confined him to bed for several weeks. On recovering from this the leg became œdematous and the veins markedly varicose. This condition lasted for a year, when red macules made their appearance on the foot and spread up on the leg. These were the first indication of the disease which is here described. When he came under observation the skin of the leg, especially that of the extensor aspect, presented numerous circumscribed dark red or violet lesions; these were not raised above the level of the skin, were roundish, oval, or irregular in shape, and reached the diameter of a mark in size; their surface was smooth and hairless, and their consistence soft. Besides these there were raised infiltrated patches and nodules. The chief peculiarity was the presence of these circumscribed, soft, violet-tinted areas, the softness being the result of a marked dilatation of the underlying lymphatic spaces, which alone differentiated the histological picture from that described by Kaposi, and suggested the title to the writer.

J. M. H. M.

MOLLUSCUM CONTAGIOSUM. CHARLES J. WHITE and W. H. ROBESY, jr.
(*Journal of Medical Research*, April, 1902, p. 255.)

THE authors give a lengthy review of the extensive literature upon the histology of this affection, first described by Bateman in 1817. They also give a complete summary of those who have upheld or uphold the view (1) of its sebaceous origin; (2) of its rete origin; also of its being contagious or not (of the former there are twenty-seven, of the latter only eight); also of those who think the "bodies" are degenerated epithelial cells, and those who think they are parasitic.

The histological and bacteriological investigations made by the authors themselves from two cases lead them to the conclusion that;—

(1) The so-called molluscum bodies are merely keratin, identical with the horny layer, except in the shape of the individual cells, and represent an extraordinary metamorphosis of rete cells into normal keratin.

(2) That as yet no true parasitic body has been demonstrated in the growth.

(3) That bacteriological examination of the tumours is negative, and that some new medium or stain must be devised to demonstrate the causative agent.

ARTHUR HALL.

CASE OF ARTHRITIC PURPURA. W. C. KELLOG. (*American Medicine*, March 22nd, 1902.)

A BOY aged 14, with slight rickets in early childhood, scarlet fever and nephritis when seven. It began in 1900 with attacks of colic and diarrhoea, accompanied by urticaria, lasting only a few days, but reappearing at intervals. The eruption was chiefly on flexor surfaces of forearms, and there was frequent epistaxis. For about a year the attacks diminished in severity, but did not wholly disappear. In August, 1901, after several attacks of colic, occasionally with tarry stools, a general erythematous eruption appeared all over the body, especially on the flexor surfaces of the fore-limbs, with numerous small hæmorrhages into them. He is anæmic, the heart and spleen both enlarged (no statement as to pyrexia or condition of heart-sounds), and there is trace of blood in urine. He has suffered lately from attacks of joint pains.

ARTHUR HALL.

A CASE OF ALOPECIA AREATA. LEVY. *Journ. des Mal. Cut. et Syph.*, May, 1902.)

THE author describes an interesting case of Alopecia areata affecting man and wife. In the man alopecia, vitiligo, and blanching of the hair and beard occurred almost at the same time after emotional trouble in a patient of a neuro-arthritis diathesis. The wife, also a neuro-arthritis subject, suffered from the same emotional cause, and had loss of hair and eyebrows.

In these cases the etiology appears to be tropho-neurotic. The occurrence with vitiligo is of interest. In the male the patches were typical of Alopecia areata; in the female they were irregular and disseminated.

C. F. MARSHALL.

THE TREATMENT OF FURUNCLE. DESFOSSES. (*La Presse Médicale*, July 9th, 1902.)

THE author mentions that in 1880 Pasteur showed that furuncle is caused by an acute infection of the pilo-sebaceous apparatus by the *Staphylococcus pyogenes aureus*. Furuncle may be local or general,—the former requiring local treatment, the latter general treatment in addition.

Local Treatment.—When seen early, abortive treatment should be tried by painting with tincture of iodine. If there is a drop of pus, this must be opened before applying the iodine. If the boil does not abort, other treatment is required. A carbolic acid spray of a 2 per cent. solution may be sprayed on to the boil for two hours daily, the skin around the boil being protected. Another method is to apply warm compresses of gauze soaked in 1 in 2000 sublimate solution and covered with gutta-percha. These are changed five or six times in twenty-four hours. When the boil has arrived at maturity, it may be incised or treated with the thermo-cautery. The incision should be deep, and if the boil is large, cruciform. After incision the core is easily removed as a rule. If the boil is on the face, incision should be done early to avoid phlebitis.

General Treatment.—Many drugs have been recommended for furunculosis, such as tar preparations, alkalies, arsenic, sulphur, naphthol, and salicylate of bismuth. Brocq has recently recommended yeast, and regards it as a specific. A teaspoonful of yeast is mixed with a glass of mineral water and taken thrice daily before

meals. This treatment is said to cause disappearance of the boils, and also to prevent the formation of new ones. But it does not act in all cases. Sometimes the yeast causes digestive troubles and diarrhoea, but this probably depends on the quality of the yeast. To avoid this a preparation of yeast has been made suitable for injection into the buttocks.

Preventive Treatment.—If furunculosis is connected with glycosuria or any constitutional disease, medical treatment is required. Locally soap baths, alcoholic lotions, and minute care of the skin often prevent the return of boils.

C. F. MARSHALL.

SECONDARY SYPHILIS WITH NERVOUS SYMPTOMS. HYSTERIA AND POLYURIA. MALHERBE. (*Journ. des Mal. Cut. et Syph.*, May, 1902.)

THE author quotes Fournier, who states that secondary syphilis may cause all kinds of neuroses which did not previously exist, and may also stimulate or revive certain pre-existing neuroses. Hysteria is often developed, at other times epileptiform crises. Rarely there occur cardiac troubles simulating angina pectoris or mitral stenosis. The appetite may be affected in both ways, viz. anorexia on the one hand, and bulimia and polydipsia on the other. More rarely polydipsia occurs with polyuria or diabetes insipidus.

The author reports the case of a woman of 23 years who had contracted syphilis a year ago. In the secondary period the patient suffered from extreme thirst, which persisted up to the time of observation. There was polyuria, especially at night. The patient complained of tingling of the arms and legs, constant desire to urinate, and frequent headaches. There was left hemi-anæsthesia. The pharyngeal reflex was abolished, taste was diminished, and there was frequent nausea. The field of vision was diminished. On the skin there was no syphilitic eruption present, but a tendency to dermatographism. The amount of urine passed in twenty-four hours varied from 10 to 14 litres. The urine contained no albumen or sugar.

Nervous symptoms in secondary syphilis may remain for a long time, and sometimes attain a great intensity, but they always disappear, especially under the influence of specific treatment.

C. F. MARSHALL.

PAPILLOMATOUS PALMAR AND PLANTAR POROKERATOSIS. MANTOUX. (*Annales de Derm. et de Syph.*, January, 1903, p. 15.)

THE case was an in-patient at the Broca Hospital, under Brocq's care. She was a domestic servant aged 25; there were no incidents of interest in the family or personal history. The affection had dated from eighteen months previously, commencing as a warty excrescence in the distal phalanx of the right middle finger. Within the last six weeks fresh lesions had appeared on the palmar surface of the other finger. In the first twenty-four hours of their appearance these lesions are granular elevations the size of a pin's head, looking a little like the vesicles of dysidrosis, but of firm consistence. After five or six days they have increased in size to equal that of a large pin's head; in the centre a black spot is visible in the deepest part of the lesion. This black spot grows and appears lobulated. Later on there is some loss of substance in the centre, leaving a small

crateriform depression. Some of the lesions become confluent in places, and a diffuse hyperkeratosis results, giving the appearance of a verrucose nævus. There were no subjective symptoms, except when the elevations were pressed, when a sensation of "pin-pricks" was felt. Two months after the first observation a fresh crop of numerous lesions developed on the palmar surface of the fingers and hands. Histological examination showed the tumours to be small papillomata, with dilated blood-vessels, in some parts of the section giving rise to hæmorrhages, and a circumscribed hyperkeratosis, chiefly in the centre of the tumour, apparently localised round the sweat-orifices. The surrounding skin was perfectly normal. The localisation round the sweat-orifices is the author's reason for giving the affection the name porokeratosis, but he is careful to state that it is widely different from the porokeratosis of Mibelli. Only two cases quite analogous to the case here reported have been placed on record: one by Besnier, of which a model exists in the St. Louis Museum, which is labelled "Symmetrical erythematous keratoderma of the extremities, punctate form; keratosis, localised to the sweat-orifices, palm of hand;" and another reported by Hallopeau and Claisse (*Bulletin de la Soc. Française de Derm., etc.*, 1891, p. 117).

A bacteriological investigation of the tumours proved negative.

The paper is illustrated with two plates of the clinical appearance of the lesions, and four cuts showing the histological characters.

E. GRAHAM LITTLE.

FŒTAL ICHTHYOSIS IN ITS RELATIONS WITH COMMON ICHTHYOSIS. MENEAU. (*Annales de Derm. et de Syph.*, February, 1903, p. 97.)

THIS is an attempt to demonstrate the pathological identity of foetal ichthyosis with common ichthyosis, two diseases which are often regarded as separate and distinct. Three types of the first class are differentiated, viz.:—(1) Grave or fatal, in which the degree of ichthyosis is incompatible with life; this is the diffuse keratoma of Lebert. (2) Ichthyosis of a medium intensity, in which the disease is also of intra-uterine development, but in which life is possible for some days or months after birth. (3) Slight or attenuated ichthyosis, in which the disease is apparent at or after birth,—that is, is extra-uterine in development. The term "foetal ichthyosis" is by older writers restricted to the first of these types.

The thesis which the author sets out to prove is sustained by the following arguments:—The clinical differentiations chiefly relied upon to separate the two diseases are examined in detail. Of these the principal, the difference in the sites of election, is shown to be not so constant, and the argument derived from it not so convincing, as has been thought. The author sums up by saying that in neither form is the complex of symptoms so different as to prohibit the identification of the two diseases as one and the same morbid process. And this conclusion is still further borne out by the histological characters, the differences here noted being not of kind but of degree. The question of heredity is considered, and it is shown that while common ichthyosis is not universally inherited, foetal ichthyosis is not infrequently a family and transmitted disease. An extremely full and careful bibliography is appended to this noteworthy paper.

E. GRAHAM LITTLE.

THE ANATOMO - PATHOLOGICAL CHARACTERISTICS OF SYPHILIS. Prof. J. RENAUT. (*Rev. Prat. des Mal. Cut., Syphil et Véné-riennes*, January, 1903.)

M. RENAUT says that all syphilitic lesions, whether chancre, macule, papule, or gumma, are, anatomo-pathologically considered, structurally the same, viz. a reactionary defensive work against a pathogenic agent, which, at a certain stage, gives rise to an endarteritis of a special kind, slowly obliterating, and tending from the first to excite the production of hypertrophy of the tissues about it.

The chancre corresponds to an arterial cone,—that is to say, an area corresponding to the distribution of an artery and the distribution of its branches. The lesion consists of a hard and elevated œdema, formed according to the kind of tissue it occupies. There is but one law governing the marked œdema of blood-vascular origin, and all the later lesions of syphilis follow it.

In the early secondary phenomena we find a vast number of arterial cones at the points of bifurcation of the arterioles to the skin, implicated by the pathogenic syphilitic agent. In the papule, the tuberculide, or gumma-stage, larger and more important vessels are involved. The microscope shows the inner coat of the affected artery, distinct and thickened, sown over with young cellular elements, raised up throughout its circumference into converging folds, which limit and finally obliterate its lumen. As a result, throughout the whole of the corresponding cone there arises an œdema, an infiltration of leucocytes, a call upon the fixed cells of the adjacent tissues, inducing in these tissues a process of sclerosis, and leading to a more or less complete blood-starvation of the tissue supporting the arterial cone. Even the so-called parasymphilides (and M. Renaut thinks we have no more right to speak of a parasymphilide than of a paratuberculide) may be explained in this way. The history of a syphilitic invasion may in a few words be described as an attack, from start to finish, on the arterial system. If one succeed in arresting the motive force, one will arrest the movement, save the case where this shall have caused irreparable damage, for example by destroying the higher elements which, once suppressed, are no longer renewed.

A. SHILLITOE.

THE INJECTION OF BINIODIDE OF MERCURY IN AQUEOUS SOLUTION IN THE TREATMENT OF SYPHILIS. E. EMERY and M. DRUELLE. (*La Presse Médicale*, February 11th, 1903.)

THE writers point out that the injection of biniodide of mercury in the treatment of syphilis is not of recent date. It was formerly used in an oily solution by M. Panas, Dieulafoy, and others. These authors preferred a solution of 4 milligrammes to the cubic centimetre. The method in vogue was to increase the dose of mercury previously used, and in order to do this it was necessary to introduce several cubic centimetres of oily liquid into the tissues. M. Lafay also prepared oily solutions of the biniodide containing 1 and 1.5 c.cgm. per cubic centimetre; these products are difficult to manipulate on account of their thickness and density, and often cause painful sensations when administered daily. Having described the method of preparation of the aqueous biniodide solution, the authors quote a number of instances in which they used it with success. Among these, a large ulcerated chancre healed in ten and another phagedænic chancre completely

cicatrised in twelve injections. Two cases of generalised acneiform and lichenoid syphilides yielded rapidly to seventeen and nineteen injections respectively, and similarly, three cases of palmar and plantar syphilides are noted as having healed after eighteen, nineteen, and twenty-two injections; in such cases, which are reputed to be slow and difficult of cure, the rapid effect of the biniodide is insisted on.

In tertiary manifestations of various kinds its action is also remarkably efficacious. For instance, a case of rupial syphilides recovered in six injections, and one deep-seated gummata of the leg in ten, and of the parotid region in twenty-one injections.

A tertiary ulcerative form of glossitis yielded to nine injections, and the same favourable result was obtained in a case of osteo-periostitis of the radius after fifteen injections.

The solution was administered in doses of 2 or 3 cgm. daily in nearly all the cases.

Diarrhoea and ptyalism were occasionally met with, and in a few instances the injections were painful or were followed by indurated swellings.

In conclusion, the writers do not advocate the use of the watery solution of biniodide to the exclusion of the insoluble salts, such as calomel in certain cases and grey oil, the use of which has their support for prolonged treatment. They claim for it, however, an important place amongst the soluble mercurial preparations, which find their employment in well-defined cases—for instance, when rapid healing of persistent or exposed lesions is required, or when it is unnecessary to give a prolonged course of treatment. The aqueous solution of the biniodide has the advantage over the other soluble injections of having been experimented with and tolerated in larger doses. It is easier to use than the benzoate, and more convenient than the cyanide, which are the most frequently employed of the soluble mercurial preparations.

S. E. DORE.

THE BRITISH JOURNAL OF DERMATOLOGY.

AUGUST, 1903.

AN ANOMALOUS CASE OF ERYTHEMA MULTIFORME IN A PATIENT WITH CARDIAC AND RENAL DISEASE.

By ARTHUR WHITFIELD.

THE extremely interesting case here reported was for some time in the wards of King's College Hospital, and it is with the kind permission of the late Professor Curnow that I now record it.

Rose S—, aged 19 years, was admitted into King's College Hospital on January 23rd, 1902, suffering from pain in the abdomen and the passage of blood *per rectum*.

Her family history showed a decided tendency to tuberculosis, one brother having died of phthisis and one sister of pleurisy.

The patient herself had been quite healthy until two years ago, when she suffered from swelling of and pain in the legs, which laid her up for about ten days. She had never suffered from any other serious disease, but she was apt to have pain in her legs since this attack, and suffered from severe headaches. Her occupation was standing all day in Covent Garden Market.

A month before admission the patient began to pass small quantities of bright blood with her fæces, accompanied by burning pain, and she also became troubled with bleeding from the gums and nose.

On admission she was found to be suffering from advanced mitral incompetency with some pulmonary congestion, but compensation

seemed fairly good. The examination of the abdomen revealed only indefinite tenderness. The urine was of sp. gr. 1010, acid, containing a good deal of blood and albumen, with hyaline and granular casts. The urea amounted to 264 grains per twenty-four hours.

She was treated by free purgation, and later with small doses of arsenic and iron, and considerable improvement took place, so that she was well enough to go out on February 20th, 1902. Her condition was then good, but she had still, of course, the mitral disease, and the kidneys were considered to be in a state of chronic fibrosis.

During the whole of her first stay in the hospital the temperature had been slightly and irregularly raised, varying from 99° to 101° in the evening, and dropping to normal or 99° in the morning. One week after leaving the hospital she again fell ill, her chief symptoms being pain in the legs, sickness after food, and severe frontal headache. She was readmitted on February 27th, 1902, in a drowsy condition, complaining when roused of pains in the limbs, while her breath had a strong urinous odour. She was given 15-grain doses of Pulv. Scammonii Co. and Pulv. Jalapæ Co. each night, and hot-air baths for about half an hour every other day, the diet being restricted to milk and lime water. Under this treatment improvement was again rapid, and on March 8th the treatment was changed to one drachm of magnesium sulphate and five minims of tincture of belladonna three times a day. On March 10th she was given an injection of pilocarpine, and this was repeated several times. On March 19th she was well enough to get up in the afternoon, and she continued to improve until April 1st, when her temperature suddenly rose to 102.2° , and an eruption appeared upon her face.

Two days later the rash spread down to her arms, and some appeared upon her chest. She was isolated at once on the appearance of the rash, as there was a great deal of smallpox about and the eruption strongly resembled that of smallpox in some particulars, though Dr. Curnow was always confident that it was not that disease. I was asked up to see her, and found the following condition:—On the face were numerous thick scabs, especially around the lips and mouth, but here and there could be seen hard shotty papules about three millimetres in diameter. Most of these seemed to arise in connection with the follicles, but this was not

evident in every case. Besides these papules there were also very deeply seated, extremely tense vesicles, in some cases umbilicated and with a greyish pearly hue.

The later stage of these vesicles showed slight opalescence of the contents, but suppuration did not occur in all, some drying up to scabs without any sign of infection.

No grouping was present, and peripheral extension was extremely limited. With the exception of the fever, there were no signs or symptoms accompanying the eruption beyond the soreness of the lips produced by the actual skin affection itself. The temperature subsided gradually in five days, and then continued in the subfebrile condition which was maintained throughout. The patient was vaccinated successfully during this attack. The eruption began to fade away quite rapidly, and had almost disappeared by April 16th, though there was some superficial pitting left after the falling of the scabs. On April 19th the temperature rose again to 102°, and on the 20th a fresh crop of papules appeared on the face and arms, and extended on to the chest and slightly on to the legs. Their appearance was exactly similar to that on the previous occasion, but they were much more numerous than before, so that the face was in a terrible condition, the whole of the lips and mouth being enveloped in a sheet of vesicles exactly resembling those of confluent smallpox; while numerous vesicles were scattered about on the arms and legs, some appearing even on the palms and soles. This time neither the temperature nor the eruption subsided so quickly as before, new lesions continuing to come out, so that the face was not completely clear even on June 2nd. After this, however, no further lesions appeared, and the skin gradually returned to normal. Slight scarring was left by some of the lesions, but much less than was expected by those who had seen the eruption at its height. During the second attack every sort of examination was carried out that I could devise in order to determine the nature of the eruption. The examination of the fluid from the vesicles gave either nothing or a non-liquefying and non-pathogenic staphylococcus. The inoculation of a piece of one of the lesions beneath the skin of a guinea-pig was followed by no disturbance in health of the animal. The blood examination made at the height of the second attack showed no marked abnormality, with the exception of a moderate polynuclear leucocytosis. Half of

the lesion which was excised for inoculation purposes was fixed and examined histologically, with the following result :—The inflammation was almost limited to the region closely surrounding a hair-follicle and neighbouring sweat-gland, and extended some depth into the corium. The epidermis over this lesion was raised *en masse* from the underlying papillary body, and in addition contained two cavities within the substance of the stratum mucosum. Both of these cavities and the interval between the epidermis and papillary body were filled with coagulated serum containing a very large number of polynuclear leucocytes, and immediately around these large numbers of leucocytes were present, apparently streaming up to the surface. There was also some proliferation of the epithelium around the hair-follicle and the sweat-duct. Sections stained with the acid-orcein-polychrome-blue-tannin-orange stain revealed no change in the collagen or elastic fibres, and no micro-organisms were found other than a few cocci in the vesicles. The raised epithelium and that immediately around it stained badly and appeared to be necrotic, resembling that found in the vesicating erythemata. Taken as a whole, the lesions seemed to suggest that acute bullous change found in severe toxic inflammations rather than that due to actual presence of a micro-organism. Before any of these examinations had been carried out Dr. Colcott Fox came to see the case with me, and we both inclined rather to the view that the lesions were of a pyæmic origin ; but I think these must be excluded from the results of the cultivation and experimental evidence, especially as they were supported by the histological conditions. It was certainly a great surprise to me to see these extremely severe and formidable-looking lesions clear up in the way they did, leaving only slight pitting and in some instances no recognisable scar. The condition of the patient, which seemed so critical at one time, also improved so much that she was able to leave the hospital the second time in a fair state of health, although, of course, the heart and kidneys were in an irrecoverable condition. At the time of her worst eruption the temperature was running a typical hectic course, and she was in the typhoid state. That the temperature was not due to subsequent infection, as in the secondary stage of variola, is, I think, shown by the fact that the highest temperature always preceded an outbreak of papules, and the fever subsided as they became vesicular.

One great point of interest lay in the extreme difficulty in distinguishing the eruption from that of an anomalous case of smallpox, even to those who had a large experience of the disease. Taking all the points into consideration, it seems to me that it was most likely a vesicating erythema of toxic origin, a diagnosis with which I believe Dr. Colcott Fox concurred, though neither of us had ever before seen an eruption of any kind quite similar to it.

A search into the literature has not furnished me with any information as to similar cases. Many cases of so-called pyæmic dermatitis have been published, but the findings differed from those in this case, and I have already given my reasons for believing this to be due to some toxic disturbance rather than infection of the lesion. I would also draw attention to the fact that most if not all such cases terminated fatally, and the material was obtained after death. In the face of more recent knowledge on the subject of terminal or agonal infection and post-mortem changes, the results so obtained should be received with the greatest reserve.

THE SCLERODERMIC TYPE OF LUPUS ERYTHEMATOSUS.

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I HAVE been permitted to state in the pages of this Journal my reasons for believing that Lupus erythematosus is not a disease in the strict sense of the word, but merely a pathological condition that may, owing to certain estimable influences, arise in the course of many perfectly distinct diseases of the skin. It will be unnecessary here to repeat these observations, since they are stated in full in recent numbers of the Journal.

If the theory there set forth is based on truth, it should be possible to demonstrate that any disease capable of producing œdema or erythema of the skin, when conditions are favourable, may give rise to Lupus erythematosus.

I am tempted, therefore, to give in series a number of cases which,

in my opinion, go far to support this contention. In these, a condition diagnosed by competent, not to say eminent, observers as Lupus erythematosus, is found in peculiarly intimate association with sclerodermia. I will give them in order, and reserve my remarks to the conclusion of the series.

CASE 1. (Described in Hebra's *Text-book*—English translation—New Sydenham Soc., vol. iii, p. 107.)—Schira Katharina, 33. Patient showed well-marked sclerodermia of hands, wrists, forearms, arms, front and back of the neck and upper chest, both legs, and a slight degree of the same on the face. The patient had previously come under care on account of Lupus erythematosus. She had "on the tip of the nose a spot the size of a threepenny piece, superficially scarred at the centre and bounded at the circumference by a somewhat elevated reddish border, looking as if it had been pricked. On the edge of the upper lip was a spot with a reddish border, scarred on the surface, and of the size of a pea. The skin of the face was dotted with brown (as in chloasma) and showed a few white spots, was but slightly firmer than natural, and tolerably freely movable."

CASE 2. Exhibitor Dr. Pringle (*Brit. Journ. of Dermat.*, 1894, p. 339; 1896, p. 329).—Female, aged 25. Shown for sclerodermia of the hands, forearms, and face. Fingers hide-bound in flexion. Commencing gangrene of all the finger-tips and of the skin over the knuckles (Raynaud without hæmoglobinuria). *The sclerodermic condition of the face was preceded by a bat's-wing patch diagnosed by the exhibitor as Lupus erythematosus.* This was said to have rapidly subsided under treatment, leaving the skin slightly thinned with patulous sebaceous gland orifices. Ears were permanently and considerably scarred.

CASE 3. Exhibitor Dr. Pringle (*Brit. Journ. of Dermat.*, 1895, p. 30).—Female, aged 17. On the face an accurately symmetrical bat's-wing patch of atrophied skin with patulous sebaceous ducts. The disease began last summer. The only active patch when the case was exhibited was on the lower part of the right cheek, where there was a sharply margined patch of erythema about half an inch in diameter. Hands cold, blue, and studded with erythematous patches. Gangrene of the tips of the little fingers, and threatened gangrene of several others. On the toes many patches of purpuric

erythema. Patient always suffered severely from chilblains, which became permanent two years ago.

CASE 4. Own collection.—Female, aged 26. An atrophying erythema, covering nearly the whole of the nose and cheeks, and present in the conchæ. The atrophy is very extensive, large areas of the skin being ivory-white and dotted over with the hugely dilated orifices of the sebaceous ducts. Disease affects the scalp severely as a deep erythema with induration and cicatricial alopecia. She has had chilblains for years. Hands and feet always very cold. Impending gangrene of the skin covering the finger-tips. Purpuric eruption on hands and feet. Deep purple mottling of the legs. Fingers much wasted.

CASE 5. Described by M. Déhu (*Annal. de Derm. et de Syph.*, 1899, p. 568).—Male, aged 55. Over the whole surface of the body the skin is thickened and indurated—a hard œdema, elastic and not pitting on pressure. Marked erythema and pigmentation of the whole skin. Hands somewhat deformed by chronic rheumatism, cold and violaceous. Fingers not thickened as in myxœdema, nor thin and pointed as in sclerodactylia. On the bridge of the nose and adjacent parts of the cheeks a decolourised plaque of infiltrated and indurated skin. On the thorax, flanks, and thighs many small white cicatrices standing out against the pigmented skin. These appeared to follow from crusted excoriations. Intellect, “minus habens.” Thyroid atrophied. Patient improved under thyroid. Diagnosis, myxœdema or sclerodermia.

CASE 6. Described by Dr. Brissaud (*La Presse Médicale*, 1897, p. 285; *Brit. Journ. of Dermat.*, 1897, p. 361).—Female, aged 42; duration, 5 years. Disease commenced with articular rheumatism and Erythema nodosum. A large abscess formed in connection with the right knee. Two years ago shrinking of the gums away from the teeth. A diffuse sclerodermia on the face, hands, and feet. Dupuytren's contracture. Intense bronzing of skin, suggesting Addison's disease. Later almost complete immobility, albuminuria, and death. When first seen she showed an erythematous condition over the malar prominences of six months' duration, suggesting Lupus erythematosus.

CASE 7. Described by M.M. Hallopeau and Trastour (*Annal. de Derm. et de Syph.*, 1900, p. 634).—Title, Lupus erythematosus

developing in the course of a sclerodermia with local asphyxia of the extremities and gangrene of the phalanges, in a tubercular subject. Female, aged 30, a seamstress. Case shown in 1894 with diagnosis of sclerodermia. Since that time a series of necroses have occurred on the fingers. Patient showed a diffuse sclerodermia of the face and hands. The fingers were flexed, and the tips conical and wasted. There had been some loss of substance, and on one finger a suppurative perionychitis. Near each elbow the skin was thickened, with an exaggeration of the natural folds and some desquamation. The surface was slightly depressed. In front of each knee the skin was hyperpigmented and transversely striated. A few hyperpigmented and atrophied patches occurred on other parts of the body. The skin of face was shining; lips thin. On the nose were decolourised and red plaques, irregularly and confusedly intermingled. One of these occupied the tip, and was surrounded by an erythematous areola that projected slightly. On the right side of the nose there was a decolourised patch surrounded by an erythematous zone, and a similar patch on the other side. These were separated from the tip by an erythematous *tache*, disappearing under pressure of the finger, and beginning to atrophy and turn white. On the posterior part of the right cheek was a plaque 6 by 4 cm. This presented two colorations. In the lower and inner two-thirds, and also at the superior extremity, it was white. In the upper and outer third it was erythematous, desquamating slightly, and disappeared under pressure. The skin surrounding this plaque was hyperpigmented, and one sees on its surface some islands of pigment. There was no glandular dilatation. The surface was depressed. On the left cheek was a similar and smaller patch completely decolourised, depressed, and surrounded by a pigmented border. The patient showed in addition moist râles, with dulness at the left apex of the lung.

There is a remarkable family resemblance between these seven cases. Case 5 was of doubtful nature, and there is nothing to show that the indurated white patch on the nose and adjacent parts of the cheeks was preceded by an erythema. The description given of the case corresponds closely with that of many recorded cases of generalised sclerodermia. Hence I have included it.

Of the remainder, four (Nos. 1, 2, 6, 7) suffered from diffuse sclerodermia of the face and hands. In Cases 1 and 7 the

sclerodermia was present in patches on other parts of the body, and Case 6 had diffuse sclerodermia of the feet as well as of the face and hands. In 2 and 7 there was gangrene of the finger ends.

The other two cases (Nos. 3 and 4) do not actually show sclerodermia, but they suffered from a severe form of Raynaud's disease, Case 3 showing the asphyxial type with gangrene of the finger ends, Case 4 showing the atrophic type, which is in reality a sclerodactylia, with impending gangrene of the finger ends.

The chief impression one has after reading the series is the prominence of atrophic scarring in all the cases, and the completeness and rapidity with which it appeared in some.

In Case 1 there is merely a red border. In Case 2 the notes make it clear that the erythema rapidly disappeared, "leaving the skin slightly thinned with patulous sebaceous gland orifices." In Case 3 the atrophy is nearly complete in about six months, since it is noted that the appearance corresponded to that seen in the last case, the only active patch remaining being "a sharply margined patch of erythema about half an inch in diameter." In Case 4 the atrophy was remarkable, and there was the same confused mingling of atrophic and erythematous patches so conspicuous in Case 7. In this case, as in the preceding, a purpuric erythema was noted on the hands and feet.

In Case 5 the atrophy is complete, but owing to reasons given the case cannot be considered.

Case 6 is interesting, since the erythematous condition on the malar prominences evidently gave place to sclerodermia. In Case 7 the atrophy is very conspicuous, and the picture given exactly recalls that found in Case 4. In this case, too, it is noted that the skin surrounding the patches on the cheeks is hyperpigmented. This is a very suggestive point, since in my experience disturbances of pigmentation are of very rare occurrence in other cases of Lupus erythematosus, whereas in sclerodermia they are exceedingly common.

It is easy to establish the fact that in some cases of sclerodermia erythema is a conspicuous feature. Many cases are on record, and I will mention a few of them.

The late Dr. Cavafy (*Brit. Journ. of Dermat.*, 1896, p. 275) showed before the Dermatological Society of London a woman, aged 50, suffering from morphœa. He had previously shown the case in

1895, when she was said to be suffering from a pale erythema in patches of the lower extremities. In the interval the patches had enlarged and fresh ones appeared. Six months before the second exhibition all the patches hardened; the colour faded and gave place to yellow, scar-like skin surrounded by a narrow zone of violaceous erythema. There was some ulceration in the right popliteal space.

Dr. Abraham (*Brit. Journ. of Dermat.*, 1895, p. 53) describes a case, a female, with patches of morphœa on the left shoulder, arm, and forearm, and erythematous blotches on the cheek.

Dr. Abraham (*Brit. Journ. of Dermat.*, 1899, p. 472) describes another case of circumscribed sclerodermia in a man of 70. I often saw this man. He had vivid red, indurated, rounded patches on the back, chest, abdomen, thighs, and legs, and an indurated erythema on one side of his face.

Dr. Graham Little (*Brit. Journ. of Dermat.*, 1902, p. 467) showed a boy, aged 11, with a band of sclerodermia following the supra-orbital branch of the fifth nerve. This band remained red for two years before it began to change colour and assume the aspect of a scar.

In all these cases—and more could be quoted—there is really an atrophying erythema that corresponds closely with that encountered in the seventh case of this series. And the comparison is not altogether fair, since the cases last quoted are instances of circumscribed sclerodermia, whereas those in the series are of the diffuse type, in which the atrophy is more intense and more rapid.

Hence it is difficult to put forward any good reason why the cases in the series should not be regarded as really sclerodermic in nature.

There is an interesting case described by Mr. Hutchinson (*Archives of Surgery*, 1893, p. 365) that illustrates the difficulty of diagnosis. The case was sent to Mr. Hutchinson by Dr. Abraham. I will quote it as it is given:—"Exactly in the centre of each flush patch of the cheek there is a round shilling-sized area like ivory. The reasons for believing that these patches result from Lupus erythematosus, and not from morphœa, are the following:—Their margins are distinctly erythematous and slightly swollen, and there are some little red discs close to them (satellites), which she says well represent the early stage of the patches on her cheeks. There is also some roughness over the whole of the bridge of the nose,

and the patient states that she had formerly patches in that position. . . . The patient suffers very much from chilblains. Her fingers are covered with erythematous papules, some of which present depressions in the middle."

This case was, I believe, sent to Mr. Hutchinson as an example of morphœa. He held it to be Lupus erythematosus. According to my view it could be both. For I have contended that any erythema or erythematous eruption can, if the circumstances be favourable, undergo atrophy, and this atrophy represents the best mode of healing that the part is capable of at the moment. Usually the healing is greatly prolonged, owing to the fact that the vessels of the part are merely damaged but not destroyed, and also to the important fact that the exciting causes, *e.g.* cold, exposure to sun, etc., are still operating. Then the diagnosis of Lupus erythematosus is unquestioned. But in other cases the passage into atrophy may be so rapid and complete that the case is labelled sclerodermia or idiopathic atrophy of the skin from the beginning.

In the cases of the series the circumstances are distinctly unfavourable to the complete *restitutio ad integrum* of any skin lesion,—that is to say, decidedly favourable to atrophy or dry necrosis. And that is what usually occurs. The chilblains, from which they suffer so much, persist, and frequently undergo central necrosis. The follicular lesions of the legs and arms, so common in all subjects, also necrose in the centre, owing to their inability to heal or to undergo frank suppuration. In this condition they are often classed as toxi-tuberculides, on what appears to me to be as insufficient evidence as that on the strength of which Lupus erythematosus is placed in the same group. Such patients are obviously prone to tubercular affections, as also to simple catarrhs of every description. Owing to their circulatory defects they are all "bad lives" from an insurance point of view. But it does not in the least follow, nor is it probable, that these necrosing skin lesions are in any way tuberculous in nature.

A very interesting case is recorded by Sir Stephen Mackenzie (*Brit. Journ. of Dermat.*, 1898, p. 51). A female aged 26. Patient came under the exhibitor's charge in 1886 for patches of morphœa on each side of the trunk, which shortly underwent involution, leaving pigmented patches, which are still present. At the second

time of exhibition the helix and lobule of both ears were withered and contracted, and on the lobules were small patches of depressed (cicatrised) skin with dry crusts. On the face in front of the right ear were two pea-sized areas having a punched-out appearance, the base being red and smooth. On the scalp were curious irregular depressed areas (1 mm. \times 0.5 mm.). They have abrupt edges, a dry and scar-like base. On the left side of the face was an irregular erythematous patch 4 mm. long. The lesions on the ears started as small hard lumps, which enlarged, became red, and discharged blood and matter. For two years they alternately healed and discharged, leading to gradual destruction. All the members of the Dermatological Society present agreed that the lesions were of the nature of Lupus erythematosus.

I have excluded this case from my series, but with the feeling that it is closely allied, and that it should be considered together with them. The withering of the ears that occurs in so many cases of Lupus erythematosus is singularly like that encountered in the diffuse type of sclerodermia.

The main difference between the two diseases is that Lupus erythematosus attacks the superficial parts of the skin, whereas in the majority of cases sclerodermia attacks the deeper layers, and especially the subcutaneous tissues in which the larger vascular trunks lie.

But it is interesting to note that the more superficial the sclerodermia the more is it apt to resemble Lupus erythematosus.

Another interesting and suggestive point is that there are certain histological resemblances between the three diseases, Lupus erythematosus, Lichen planus, and the superficial type of Sclerodermia called by Unna "card-like." In Lichen planus atrophicus the two last named come so close together as to be almost identical.

The general picture of the three diseases is by no means the same, but the details bear a close resemblance. There is the same marked disturbance of the basal layer of the epidermis in all, the same infiltration of small cells of a similar type lying immediately beneath the epidermis, and surrounding the ducts, follicles, and blood-vessels. These cells are poor in protoplasm, and appear to have few processes. In sclerodermia they may disappear rapidly before the advancing sclerosis; but where present they closely

resemble those met with in the other two, both as to type and arrangement. The main difference lies in the behaviour of the vessels. In Lichen planus the vessels are relatively little damaged, and are able to return to their normal condition as soon as the cell collection has disappeared. In Lupus erythematosus the vessels are dilated in an extreme degree, and usually the only possible termination is a gradual obliteration, leading to scar-formation. This naturally may take many years to happen.

In sclerodermia the vessels are narrowed or obliterated from an early stage. As a consequence the cell collection is slight, or may be absent, and the passage into scar tissue is extremely rapid. It is well to note how much an œdema of the tissues favours cell multiplication and hinders their disappearance. So long as the cells persist, a perfect scar cannot result, since such a scar is practically acellular.

Histologically, therefore, there is a close connection between Lupus erythematosus and the superficial types of sclerodermia. So close is it, in fact, that it is possible to conceive of them as being the same malady influenced merely by the power of resistance of the vessels. In the latter the vessels give way at once and become entirely obliterated. Hence the rapid scar-formation and the great tendency to necrosing lesions. In the type of Lupus erythematosus now under consideration in this paper the obliteration of vessels is apparently very rapid, as evidenced by the passage of the erythema into atrophied and sclerosed patches.

In this connection a case of Lupus erythematosus disseminatus described by the late Dr. Cavafy (*Brit. Journ. of Dermat.*, 1897, p. 328) is singularly interesting.

A female, aged 22. Disease commenced on the hands seven years before, and slowly increased till the time of exhibition. The dorsum of the fingers and ulnar border of the hands were covered with vivid red, slightly scaly patches, in many cases become confluent to form large patches. The patches have irregular outlines, are bounded by sharp borders, and are slightly depressed. *The tips of both little fingers atrophied.* A few scaly patches were present on the palmar aspect of the fingers, and on the thenar and hypothenar eminences. *In cold weather fingers became dead,* but there were no chilblains. Four years ago patient suffered from severe inflammation of face, ears, and back, with some

fever. It was first called erysipelas and then eczema. The inflammation subsided, leaving the ears and back scarred, and some patches on the face which have spread since. Condition when exhibited :—Ears stiff, red, scaly, superficially scarred. Pale red scaly patches on the right cheek, tip of the nose, and on the chin. These appear to be involuting. *Some show slight pigmentation.* The upper lip swollen, sore, red, scaly, the swelling extending to the inner mucous surface. Scalp free. On the outer aspect of the right arm, over the deltoid insertion, an oval, dull red, scaly patch. The back, from the upper interscapular region to the lower dorsal region, occupied by a large grey superficial scar.

It is fair to use the word “sclerodermic” to describe a case like this, without necessarily implying that the two processes are allied or identical. My own personal belief is that sclerodermia, like Lupus erythematosus, is not a distinct disease, but merely a pathological state occurring in the course of other diseases, of which the chief are rheumatism and urticaria. I believe further that sclerodermia forms the end of a pathological chain of which Lupus erythematosus is the middle, and that the cases under consideration are on the boundary line between the two. However, personal beliefs are of little value, and I hope to be able to take up the subject again on some future occasion.

Conclusion.—There occurs in patients who suffer from diffuse sclerodermia of the face and hands, or from Raynaud’s disease, a form of atrophying erythema, marked by the preponderance of the atrophy over the erythema and by the rapidity with which the atrophy often ensues. These patients show a marked tendency to gangrene of the finger ends, and to the appearance on the hands, and often on the feet, of erythematous lesions, sometimes purpuric in character. Till more accurate information is forthcoming as to the relationship of Lupus erythematosus and sclerodermia, these cases can very well be provisionally known as the sclerodermic type of Lupus erythematosus.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of the above Society was held on Wednesday, July 8th, 1903, Dr. J. A. ORMEROD in the chair.

The following cases and specimens were shown :

Dr. ADAMSON showed a girl aged 10 years, suffering from *Lupus erythematosus* of the hands and feet. The eruption first appeared in the early part of the summer of 1902, as red raised patches upon the fingers and toes ; during the summer it spread up to the wrists, the nails became red, and the finger-tips swollen around them. On the feet, the toes and heels were chiefly affected. When at their worst many of the patches "cracked," and oozed "a little water," but there were never any blisters ; on the heels the patches became "like broken chilblains." During the winter the eruption completely disappeared, but left fine white scars on the fingers and ulnar borders of the hands. The eruption has appeared again this summer. It now consists of irregularly rounded or oval, red, slightly raised, and fairly well defined non-scaly patches, the largest about half an inch across ; the redness disappears on pressure, leaving a little brownish stain. The patches are situated on the dorsal surfaces of the thumbs and fingers, and along the ulnar border of each hand ; on the foot there is now only a small erythematous patch at the tip of the great toe. Between the patches are fine white superficial scars. The third and fourth left finger-nails are ridged and dusky red in colour, from an erythematous condition of the nail-matrix beneath.

The fingers are painful when knocked, but there is no itching or other subjective sensation. There are no lesions in any other part. There is no family history of tubercle, nor evidence of tuberculosis in patient. Urine normal.

The facts that the extremities are not cold, and that the eruption disappeared entirely during the winter, distinguish the lesions from those of "chilblain circulation." The recurrence during the summer months suggest at first an erythematous form of summer eruption, but there are no vesicles and no papules, and the face is not affected. The case is regarded as one of *Lupus erythematosus*, the disappear-

ance of lesions during the winter being accidental; or possibly the summer outbreaks are explained by the sun and heat as an exciting cause. A point of interest is the affection of the nail-matrix, with dystrophy of the nails.

Dr. BAUMANN (introduced by Dr. Penrose) showed two cases from the Hospital for Sick Children, Great Ormond Street. These had been recently admitted as cases of Raynaud's disease, under the care of Dr. A. E. Garrod, by whose permission they were shown.

CASE 1.—Charles S—, aged 4½ years, was admitted on June 11th, 1903. The case was an obvious one of *Raynaud's disease*, with a wide-spread distribution involving the feet, hands, ears, nose, and lips. The parts affected were cold and swollen, and dark blue in appearance. The illness was of twelve months' duration, and was always aggravated by the occurrence of cold weather. No hæmoglobinuria was present, although very dark-coloured urine was said to have been passed during some of the previous exacerbations.

The condition greatly improved in hospital, leaving now only slight swelling of the hands and a small patch of dry gangrene on the helix of the left ear.

CASE 2.—James S—, aged 9 years. The patient was a thin, delicate-looking child. The eyelids bore a bluish tinge, and the helix of the left ear was hot, swollen, and painful, and of a purple colour. Several fingers and toes on both sides were swollen, hot, and painful, and of a brownish-red colour. On two fingers and one of the toes the skin had given way, and an ulcer formed. On the left calf and right shin there were scars, the skin over which was hardened, and had an irregularly reddened, scaly appearance. The illness was of six months' duration. The patient is said to have always been subject to great sensitiveness to cold. The condition improved considerably in hospital, but is still sufficiently well marked.

In neither of these cases was the family history at all significant, no strong hereditary tendencies being elicited.

Remarks.—The first case was obviously one of Raynaud's disease. It is of interest mainly in contrast to Case 2, for the occurrence of this disease in children, although comparatively uncommon, is yet not extremely rare.

Case 2 was at first regarded as an instance of this disease also, but doubts were soon raised. Dr. Penrose, who saw the case with Dr. Garrod, suggested the diagnosis of Chilblain Lupus in view of the distribution and appearance of the lesion, and, perhaps, of the scars referred to on the legs. There seems to be no doubt that the case is the result of some disturbance in the mechanism of the vaso-motor functions.

The general opinion of members present was that it was purely a case of vaso-motor disturbance, and that it was inadvisable to use the term "lupus."

Dr. ORMEROD showed a case, by permission of Dr. Gee, under whose care the patient was. The patient was aged 75, apparently in good general health, a rope-maker by trade, living at Abingdon. On the backs of the hands were two large irregular patches of dark blue discoloration, symmetrically placed. The edge was well defined, and on the right hand firm to touch; on the left hand mapped out by small, firm, prominent nodules. One finger was blue and swollen. On the feet, legs, and thighs were other blue patches, some of them bordered by tiny nodules, while some parts showed firm, projecting, almost pedunculated tumours the size of small marbles. The lower limbs were somewhat swollen. There was a small blue patch on the right eyelid; and Mr. Pernet remarked another, of considerable size, upon the palate. It was mentioned that Mr. Jonathan Hutchinson had seen the case, and considered it identical with two cases described by himself, and with the so-called "Sarcoma melanodes" figured by Hebra. In the present case there was no history of gout, and, except for a certain degree of cardiac dilatation, the patient seemed quite well.

Dr. F. G. PENROSE showed a girl aged 10 years, suffering from *Psoriasis*. The interest of the case lay in two points—namely, the strong family history of the disease, and its unusual distribution. The mother, the mother's brother, and the mother's father had all suffered from psoriasis, and the child exhibited was the only one out of a family of eight who had the disease. The chief distribution of the eruption was on the body and the flexor surfaces of the limbs, though there were scattered lesions elsewhere; and it was especially to be noted that both the palms and soles showed small lesions scattered over their entire surfaces.

Dr. J. J. PRINGLE brought forward (1) the man shown at the May meeting of the Society* whose condition suggested the possibility of the case being one of Blastomycetic Dermatitis. The largest granulomatous growth had been excised from the left cheek and submitted to microscopical examination by Dr. Whitfield, whose report ran as follows :

Sections cut across the ulcer in a direction perpendicular to the surface showed that the disease affected almost the entire thickness of the corium. The epidermis was lost in the centre of the section, and showed the usual hyperplasia at the edges ; but there was obviously no malignant character present. Below the epidermis there was a rather dense infiltration of cells, attaining its acme at about the middle of the corium, lessening in the deeper parts, and changing its character somewhat as it came to the surface. This main part of the infiltration consisted of rather ill-formed plasma-cells and small lymphoid cells. The arrangement of these followed the normal appendages of the epidermis and the vessels, as is always the case in chronic inflammation ; but there was no special tendency to the formation of a marked peri- and mesarteritis such as is usually found in syphilitic lesions. One vessel showed a very marked proliferation of the intima, causing a valve-like closure of the lumen, but this did not resemble that seen in syphilis. The upper part of the infiltration was formed chiefly of polynuclear leucocytes, and was of an obviously septic nature. The surface was very rich in fibrin, as shown by Weigert's method, and this interfered to some extent with the staining for cocci by Gram's method. On the other hand, sections stained by Pappenheim's method showed the cocci in small mulberry-like masses in the most superficial parts of the ulcer, giving the impression that they were merely small colonies growing in the exuded serum, and not the original cause of the disease. Sections had been stained in considerable numbers by the Ziehl-Neelsen method, in spite of the fact that there was nothing present to suggest a tubercular origin, and no bacilli had been found. Blastomycetes had been carefully searched for in many sections, but without success ; and considering the ease with which these bodies are found in sections where they are present, it might be considered certain that the disease was not a blastomycosis. The whole of the

* *Brit. Journ. of Derm.*, vol. xv, No. 6, p. 211.

features taken together showed simply a chronic inflammatory and septic ulcer, and might be said to offer no help in determining the nature of the disease.

Although the diagnosis of blastomycosis was absolutely excluded by this careful examination, the case still presented many points of obscurity, and the idea of the condition being a mere staphylococcia recommended itself neither to the exhibitor, the researcher, nor to the Society at large. Cultivation experiments resulted in nothing except pure growths of *Staphylococcus aureus*. The idea suggested by some members of the Society that the ulcers were syphilitic, apparently on the ground that their margins were much raised, infiltrated, and hard, was negatived by the complete failure of iodide of potassium administered in ten-grain doses three times daily for many months, and continued "on the off chance" by the exhibitor.

The patient had been submitted to X rays daily since he was previously shown, and marked improvement had resulted. One of the ulcers had completely healed, and the other two had cicatrised over, but their margins remained firm and prominent. The wound caused by excision of the largest growth healed by first intention.

(2) *A lichenoid eruption for diagnosis*, in a woman aged 49, which she stated to be of eighteen years' continuous duration, although it had undergone numerous exacerbations and remissions. She had been treated in various ways, although apparently with little persistence. Previous to the appearance of the present eruption she had suffered from a sore on the lip, followed by throat trouble and an extensive skin eruption. According to the patient's impression, the two eruptions were continuous. The condition for which she was exhibited was fairly accurately symmetrical, and present over the fronts of the lower forearms, flexor surfaces of elbows, the lower parts of both thighs and upper parts of both legs, and abundant in the inguinal regions and over the buttocks. The type of eruption was everywhere identical. Its constituent lesions were faintly elevated papules, shiny when viewed by oblique light, and grouped to form plaques and very roughly circular figures, both of which were deeply and apparently permanently pigmented—the pigmentation being, as usual, most accentuated on the lower limbs. The skin covered by these conglomerate plaques and circles showed deepening of the natural lines of the part, the result of finely atrophic changes; and on close inspection the areas of apparently healthy skin between the manifest lesions exhibited the finest possible "granular" lichenification.

Of the lesions on the legs a large proportion were clearly follicular, but no acuminate or pilaris lesions were detected. The mucous membrane of the mouth was healthy.

The patient's statements as to itching were extremely contradictory, but evidently the symptom was never very marked, although more prominent in cold than in hot weather.

No member of the Society present could arrive at any decisive diagnosis. Dr. WHITFIELD suggested the possibility of a persistent gyrate erythema, but the amount of actual infiltration seemed opposed to the view. The idea of Lichen variegatus was mooted, but the exhibitor's view that it was a badly developed Lichen planus received, perhaps, the greatest amount of support.

(3) A healthy-looking girl 24 years of age, who exhibited a large number of minute nodular lesions over the upper third of the central portion of thorax and lower part of neck, a small number of similar lesions being scattered over the shoulders. The disease was stated to have begun eight years ago in the left upper mammary region, and to have slowly spread without in any instance having disappeared either by suppuration or atrophy. The little growths were the colour of normal skin, they varied in size from a pin's head to a small pea, were hard but painless to the touch, and were very closely aggregated, especially in the supra-sternal region. Their localisation and other passive characters suggested the possibility of their being examples of one of the forms of benign cystic epithelioma; but the insertion of a needle and subsequent digital pressure resulted in the extrusion of long strings of inspissated sebaceous matter even from the minutest of them, and clearly demonstrated that they were *multiple sebaceous cysts*. On the face there were one or two extremely minute milia, but no other evidence of any tendency to sebaceous disease existed.

Dr. RADCLIFFE-CROCKER showed (1) a case of *Lupus erythematosus* in which the disease was commencing as closely aggregate, flat, red papules along the naso-labial fold. The youth, aged about 20, said that a previous attack began in the same way, and extended over nearly the whole face and a great part of the palm and forearm. This case was shown to the Society in 1902 and reported in vol. xiv of the *Brit. Journ. of Dermat.*, p. 429.

(2) A case of *Acne agminata* (acnitis) of the face combined with

folliclis of the elbows and forearms. The patient was a man aged 35, engaged in teaching. There was no history of phthisis in his family, nor in himself. The disease had come out suddenly when he was perfectly well and while he was at the sea-side five weeks previously, and was nearly all out in a week. The lesions were not aggregated so much as usual round the nose, mouth, and orbits, but were scattered over the face in small groups or singly, and there was only one nodule on the right lower eyelid. Only a few suppurated; in other respects they resembled most other cases of the disease. At the root of the neck on the right side there was a 3-inch closely aggregated group, and over each elbow there was another, and some scattered nodules on the forearms and one on the back of each hand; the forearm lesions had the characters of folliclis. In the circumstances of its onset it resembled a case shown by the present exhibitor and published two years ago in the *Journal of Dermatology*.

Dr. Radcliffe-Crocker also showed two drawings of somewhat similar cases to compare with that brought forward.

Dr. WHITFIELD showed (1) a boy aged 13 years, suffering from an eruption on the right wrist and also on both legs. The history he gave was that both wrist and legs were affected at the same time, many years ago. On looking at the wrist there was found a more or less circular red patch about one inch in diameter situated over the styloid process of the ulna. The patch had partly but not entirely cleared in the centre, so that a disc was formed, of which the margin was the most salient part. The eruption consisted of a group of large nodules of nearly the size of a split pea, and over these the skin was rough and slightly verrucose. The colour was of a very vivid red, and on pressing this out no marked yellow colouring was left behind; above all no transparency. The consistency was very firm, and there was no suppuration or ulceration. The patch was most strongly suggestive of a local tuberculosis of the skin; but on searching the legs it was found that the boy was also suffering from a very marked attack of Lichen planus, in which the lesions were uniformly follicular in site, and from this reason carrying in every instance a small follicular spine. Besides these there were well-marked thumbnail-sized patches of verrucose Lichen planus on the

shins. Dr. Whitfield said that he considered the case a very interesting one on account of two points. The first was, what was the nature of the patch on the wrist? When he first saw the case he promptly decided that this was a local indolent tubercular patch, but after seeing the condition of the legs he became undecided, and re-examined the wrist lesions in the light of the eruption on the legs. He found that the patch was not wholly incompatible with the diagnosis of Lichen planus, but he still thought that it was much more like a tubercular lesion. On the whole, if pushed for a diagnosis, he should be inclined to view it as an anomalous patch of Lichen planus. The second point of interest was that this case showed so admirably the sequence of events in the development of the verrucose patches. One saw the discrete follicular papules on the legs, and one saw these in aggregations, and again the fully formed verrucose patch surrounded by follicular papules about to become fused into it. He believed that this was invariably the method of formation of these patches, and was glad to find that this view was held for at least some cases by Dr. Radcliffe-Crocker.

All the members present who expressed an opinion about the patch on the wrist stated it as their belief that the boy was suffering from two independent diseases, and that that on the wrist was tuberculosis. Dr. Whitfield promised to report on the case later.

[NOTE.—Although too early to express a decided opinion, it is perhaps interesting to note that when seen five days later the patch on the wrist was surrounded by minute papules forming in the hair-follicles around it, and that it seemed to be yielding slightly to treatment.]

(2) A woman aged 33, also suffering from *Lichen planus*, but of the annular type. The patient had suffered with the disease for over a year, and had sought relief a year ago at the Great Northern Central Hospital. Owing, however, to her being advanced in pregnancy, she was unable to attend more than once; and now that her baby was a few months old she had returned to the out-patient department. When exhibited she had the eruption on the extensor surfaces of the arms below the elbows, and a few lesions on the thighs just above the knees. The eruption consisted of the classical plane papules and rings, varying in size from a quarter to slightly over one inch in diameter. These rings showed a slightly atrophic brownish centre, and a narrow or broad active edge. In those in which the edge was broad, and in the smaller plane lesions, the

white striæ and puncta were extremely well marked—a point in the diagnosis which the exhibitor believed, with Wickham and Darier, to be extremely valuable for diagnosis in difficult cases. In those rings where the edge was narrow, it formed the most delicate sclerotic line, suggestive of porokeratosis; but it could be seen on examination that there was no grooving, and that the ridge lay in the superficial part of the corium rather than in the epidermis. The smaller plane papules showed in every case a tendency to central evolution, with the formation of single ring-shaped papules with eccentric spread. Such cases were so rare that it was only of recent years that this mode of development into rings had been established without doubt, the common method of ring-formation being by the aggregation of papules.

Dr. RADCLIFFE-CROCKER pointed out that in those cases in which true centrifugal enlargement occurred it seemed to affect every papule alike, so that every lesion became annular. In reply, the exhibitor said he had not sufficient experience to be certain of this, but it was certainly so in those cases which he had seen; he also thought that these cases were much more resistant to treatment.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of the above Society was held on Wednesday, June 24th, 1903, Dr. J. H. STOWERS in the chair.

Dr. JAMES GALLOWAY delivered the annual oration, taking as his subject, "Erythemata as indicators of disease."

The following cases were also exhibited:

Dr. P. S. ABRAHAM showed a case of a woman aged 59, who presented an extensive nodular eruption. The lesions first appeared, about twelve months before exhibition, on the arms and forehead, lasted about a month, and then disappeared.

In November, 1902, lumps appeared on the arms and face, and spread from there over the trunk and legs. These became red and pigmented. At the time of exhibition numerous pigmented nodules were present on the face, arms, body, and legs, and there was also a

mottled discoloration and several dark, slightly raised, pigmented patches.

Itching was present at first, but this has gradually ceased under treatment, and some of the nodules have decreased in size.

On her first appearance at Blackfriars Hospital, about two weeks before exhibition, the resemblance to nodular leprosy was so great that the bacilli of Leprosy were looked for, but with negative results. The diagnosis appeared to be between Syphilis and Mycosis fungoides.

A section of one of the nodules made by Mr. Hartigan indicated an inflammatory growth, but a more extended microscopical examination will be made.

The patient was treated with iodide of potassium, and under this the nodules have certainly become smaller, the pigmentation less, and the patient has felt better in every way.

The PRESIDENT regarded the case as one of Mycosis fungoides.

Dr. ALFRED EDDOWES showed a case of *Urticaria pigmentosa*, commencing at the age of 28. He said it was on account of the extraordinarily late age at which the affection first appeared upon this patient that he desired to bring this case before the Society. He believed it was nearly, if not quite, the latest case in that respect on record. The present age of the patient was over thirty, and the disease commenced about two years ago. The man, who was a valet, had a good personal and family history. Except for the skin affection he appeared well, and only admitted a slight feeling of being "run down."

The lesions consisted of scattered papules commencing as raised, red, circular or semi-globular elevations, sharply defined and feeling firm. They soon showed a yellowish or brown pigmentation, even in the condition of œdema, which was most marked in the early stages. After their subsidence marked brown, sometimes almost black, pigmentation remained. The size of the papules varied from that of a small shot to that of a large pea. None of the lesions or remaining pigmentations measured as much as half an inch in diameter. On the site of a papule which had been excised for examination there had formed a small pigmented keloid. The lesions were very numerous, isolated, without any very definite arrangement, and at all stages of development, and were situated chiefly on back, chest,

arms, and thighs ; the hands and face being almost free. A closer observation of the hands and face showed that the circulation was not quite normal, and that the colour of skin was somewhat lilac.

Since he came under Dr. Eddowes' care the patient had spent two weeks at Aix-les-Bains, and employed the baths with benefit.

Dr. GRAHAM LITTLE showed a case of an eruption of *Toxi-tuberculides* of the type of *Acne scofulosorum* in an infant aged seventeen months. The eruption had appeared three weeks previously, the child having been before this apparently perfectly healthy. The mother was slightly anæmic, but in other respects a well-developed, robust young woman. She had suckled this child up to the age of nine months. She disclaimed all knowledge of any tubercular taint in either her own or her husband's family. The eruption had commenced on the arms, and when shown it consisted of small, firm, deeply congested papules, in many cases with a necrotic centre, and with the blue tint of cyanosis. They were very thickly scattered, without obvious grouping, on the legs, thighs, buttocks, and the arms and forearms, in the latter position being especially closely aggregated. They gave rise to no subjective symptoms whatever, and factitious urticaria was not obtainable. With the exception of a little diarrhoea during the past fortnight, there was no departure from health noticeable in the child. This was an exceptional observation in the exhibitor's experience, the children affected with this type of disease being usually cachectic and ill. The absence of all tubercular history was also remarkable.

Dr. H. G. BROOKE considered it a typical case of "*Toxi-tuberculides*."

Dr. RADCLIFFE-CROCKER was understood to concur in this diagnosis.

Dr. V. H. RUTHERFORD showed—(1) *A case for diagnosis*.—A young lady aged 23, dressmaker, with the following appearances:—(a) An eruption of red, umbilicated, pea-sized papulo-pustules, some with thin yellowish crust, others with extremely slight purulent exudation, and a few broken down into tiny ulcers, in a cluster of about forty over the right arm, and isolated over the scalp, face, ears, breasts, shoulders, with only one or two on the lower extremities; (b) distinct varioliform scars distributed over the same regions, those on the scalp resembling *Lupus erythematosus*; (c) flattened, violaceous,

gumma-like nodules, about the size of almonds, at each elbow and at the anterior fold of each axilla; (d) chilblains on several fingers; and (e) enlargement of the cervical and supra-clavicular glands on both sides. Each outburst endures five or six weeks, and during six years the patient has only been free from an attack for three months. At 10 her mother treated her for "eczema of the head," and at 14 for "anæmia." Her father suffers from bronchitis and a weak chest, and, out of five sisters and one brother, one sister has an enlarged submaxillary gland, evidently undergoing degeneration.

DRS. RADCLIFFE-CROCKER and H. G. BROOKE considered the case rare, and agreed with Dr. Rutherford that it probably belonged to the Tuberculides.

(2) A man aged 26, with fifteen subcutaneous, freely movable, painless growths (*Lipomata*), varying in size up to a walnut, and scattered irregularly over the trunk and extremities. During fourteen years the patient has observed little or no change in them.

(3) A boy aged 3, with *Molluscum contagiosum*.

MR. ARTHUR SHILLITOE showed a case for diagnosis, which had been previously exhibited at the Society in October, 1902. Patient gave the following history:—Seven years ago he had a sore of a doubtful nature, for which he was treated with medicine for about three months. In February, 1902, he developed another sore, also of a doubtful nature. In the following April two patches appeared, each about two inches in diameter, one below the right nipple, the other over the mid-dorsal vertebræ.

Each patch consisted of a central papule surrounded by a pale area, which in its turn was margined by a ring of crusted and fused papules.

The thoracic patch has completely disappeared; the one on the back is larger.

He has had no antisymphilitic treatment since the (?) medicine for three months, seven years ago, and no other sign whatever of syphilis.

DR. WILFRID WARDE showed (1) a case for diagnosis, Mabel U—, aged 4. The child was vaccinated at the age of three months on two capillary nævi. One of them ulcerated out completely. The other was not entirely destroyed. Three months

later the eruption for which she is exhibited appeared on the left cheek, and it has been present ever since with slight intermissions, the longest period of freedom, according to the mother, being two months. Each patch lasts from three to four days, and then dies away with the formation of a thin crust, which on falling leaves a very superficial scar. The disease has remained confined to the left cheek. When first seen, Dr. Warde noted that just below the outer half of the left lower eyelid there was a dusky flush the size of a sixpenny-piece, in the centre of which stood out a raised red patch about the size of a threepenny-piece, which was evenly dotted over with minute yellow spots, sunk in the tissues, and apparently vesicles in process of drying up. On the same cheek were several red stains where recent lesions had existed, and also a number of very superficial small white scars.

The weather was cold at the time, and it was noted that the other cheek was scaly, and the backs of both hands and forearms very rough and cracked. The disease, however, affects her equally in summer and winter. Fourteen days later, on May 9th, there was a fresh and quite recent patch. A cluster of small rounded vesicles, with clear contents, stood out on a deep red œdematous base. On June 20th there was another patch. All were of much the same size. The hands were not affected.

The disease was clearly herpetiform in character, and was, he thought, entitled to be called chronic Herpes zoster. It had a certain resemblance to *Hydroa vacciniforme*.

As far as he could discover, the child had never taken bromides in any form.

(2) *A generalised necrotising affection* in a tubercular subject suffering from Raynaud's disease. J. W. C—, 44, a timekeeper. Eighteen years ago an abscess appeared on the inner side of the thigh, just above the right popliteal space, the scar of which is still visible. About the same time an itching red eruption in the right popliteal space, which has persisted ever since. Ten years ago he attended at Brompton Hospital, and was said to have an ulcer on the left lung. At this present time the upper lobe of that lung is solid. There is bronchial breathing with dulness. A few râles are audible. Lower down on the same side breath-sounds are very imperfect and muffled. There are some râles to be heard over the right apex. Five years

ago an eruption appeared on his face and scalp, extending later to the trunk.

The man is pitted all over his face as if he had had smallpox. The scalp is much indurated and cicatrised. It looks dull white, rough, and scaly. There is a diffuse alopecia in form of a network. There are two recent lesions near the forehead margin. A small red papule surrounds 3—4 hairs. The centre is formed by a dry sunken slough, which on removal leaves a flat depression. There is an abundant eruption of mixed character on the front of the chest, across the back from shoulder to shoulder, in the interscapular region, and in centre of lower dorsal region. There are small lentil-sized papules that all undergo a central necrosis. These papules are both discrete and clustered. In places, especially across the upper part of the back, there are large, irregular, eczematous areas resembling that in the popliteal space, and also apparently undergoing atrophy. At the base of the neck behind, in the middle line, a shilling-sized, irregular, violaceous, raised patch, recalling the patches met with in some cases of Lichen planus hypertrophicus. This has undergone considerable atrophy. All over the chest large round and oval depressed white cribriform scars. Many still retain hairs in them. Scars are especially numerous in lower sternal, interscapular, and lower dorsal region. The thighs and buttocks thickly sprinkled over with small yellowish-brown pigment-flecks; but as far as can be seen these are not scars. The right popliteal space is completely occupied by an eczematous patch which is gradually being converted into scar tissue. The red portions are scaly, lichenoid, and very irritable. The man's hands are cold and violaceous. He has severe local syncopal attacks, and is quite unable to bear his hands in cold water, but has never had chilblains. His mother is said to have died of scurvy and dropsy. Dr. Warde disliked the name *Acne varioliformis* for this case. The man was tubercular, but he saw no reason for thinking that the skin lesions were of a tubercular nature. He looked for the explanation in the state of the patient's circulation, which helped to convert any simple skin lesion, such as a boil, a folliculitis, or a patch of eczema, into a large and ugly scar.

CURRENT LITERATURE.

CUTANEOUS REACTIONS: REACTION DUE TO COFFEE
(RÉACTION CAFÉÏQUE). CH. MANTOUX. (*La Presse Médicale*,
 May 2nd, 1903.)

ON the ground that the etiology and pathology of some of the commonest dermatoses—such as eczema, psoriasis, seborrhoides, and pruritus—are involved in great obscurity, and that anything that can throw light on these questions is of value, the author has published the following observations, which were made in the clinique of M. Brocq. On July 27th, 1902, a distribution of coffee was made to the patients of the Salle Vidal at the Broca Hospital, each patient taking about one glassful. The coffee was very strong, each glass corresponding to about 15 grammes of the powdered coffee. The following day seven out of twenty-three patients complained of fresh eruptive outbreaks. Among the patients unaffected, one was the subject of phthiriasis, two of lupus, one of sclerodermia, one of hysterical œdema, one of varicose ulcers,—all affections unlikely to present eruptive phenomena in the course of their evolution. Of the remaining seventeen patients, no harmful effects were produced by the coffee in ten, and seven presented lesions which form the subject of discussion of the paper. The eruptions observed were irritation and redness of the plaques in one of two cases of psoriasis; return of irritation and appearance of a fine papular rash in a case of pruritus; a fresh red congestive plaque in a case of seborrhoides with erythema; discrete papular erythema, the following day, in a case of urticaria; and fresh outbreaks in three out of nine cases of eczema.

From these facts the author concludes that coffee is able to provoke eruptions in the course of certain dermatoses. It is not a pure coincidence that the patients presented on the same day a recrudescence of pruritus, an irritation of patches of psoriasis, a vesicular eczema on parts of the body unaffected at the time. Nothing had been changed in their *régime*, nor in their manner of life; the coffee alone could be incriminated. The important etiological rôle played by coffee in the genesis of certain dermatoses has been demonstrated by Brocq and by Perfetti. The theory of cutaneous reactions propounded by the former observer is held by the author of the paper to apply to the facts which he has observed. M. Brocq contrasted—

1. Dermatoses which have a common, constant, well-defined pathogeny, such as the parasitic diseases (lupus, trichophytosis, pus-eruptions), artificial eruptions, and trophic affections.

2. The dermatoses which should be considered as a mode of cutaneous reaction. These dermatoses have a common character in the diversity of their etiology. They should be defined by their objective aspect alone, and all the conditions which are able to give birth to them should then be sought for. Urticaria is the most well-marked type; it is easy to define, easy to characterise in its objective form, and escapes all etiological definition because its etiology is infinitely variable. Side by side with urticaria comes true eczema, pruritus and prurigo, the lichens and lichenifications, psoriasis and pemphigus. All these dermatoses may develop with a clinical physiognomy always the same and under the most varying influences—such as external irritation, nervous shock, intoxication, auto-intoxica-

tion. They should not be, in consequence, elevated to the dignity of morbid entities like cutaneous tuberculosis, trichophytosis, leprosy; they are the simple morbid expressions of which the clinician is compelled to define the objective characters and the precise conditions of appearance, but without ever having the illusion that he will be able to find a unique cause, microbic or otherwise, for the causation of the lesions, which are simply modes of reaction of the skin.

In order to found this theory of cutaneous reactions, M. Brocq considered them under two laws:

1. A single morbid cause acting on several subjects is able to provoke eminently different eruptions in these subjects.

M. Brocq founded this law upon the study of artificial eruptions of internal causation, and related how one drug (iodide of potassium) could produce in one subject erythema, in a second acne, in a third purpura. This is a proved clinical experience. The little epidemic of eruptions consecutive to the ingestion of coffee is similarly a clinical experience; it strictly confirms the law formulated by M. Brocq, since "a single morbid cause," the coffee, acting on several subjects, provoked "eminently different eruptions in the subjects."

2. The same eruptive manifestations can be provoked by the most diverse causes.

M. Brocq cites, as a typical example, that of urticaria, which may be occasioned in the same subject by the ingestion of strawberries or mussels, contact with certain caterpillars, or the rupture of a hydatid cyst. One of the patients quoted by the author had successive outbreaks of eczema—(1) on the occasion of a storm which had frightened him; (2) after he had received bad news; (3) the day following the removal of a small epithelioma of the face; (4) on the occasion of the ingestion of coffee. Here, again, Brocq's second law holds good—"the same eruption" (eczema) was "provoked by the most diverse causes." The affections grouped by M. Brocq under cutaneous reactions which were represented in the ward at the time of the administration of the coffee were lichen, pruritus, urticaria, eczema, psoriasis, and the erythemata. Those which reacted to the coffee were those affected with pruritus, urticaria, eczema, psoriasis, seborrhœa complicated by erythema; no others reacted. Here, again, the facts fitted the theory. These facts do not in themselves suffice to demonstrate such a comprehensive clinical theory as that of cutaneous reactions; but they confirm it and throw upon it the light of a single day's experience.

S. E. DOBE.

HYPERIDROSIS IN GENERAL PARALYSIS. MARANDON DE MONTVEL. (*La Presse Médicale*, January 31st, 1903.)

THIS paper is the result of the author's observations on fifty-four cases of general paralysis, from the initial phase of the disease until death. He refers to several cases in which hyperidrosis has been incidentally noted. In France Christian and Ritti say that the sweat is often increased during the periods of excitation. Sollier simply notes the peculiar odour of this secretion; Regis, the alternatives of suppression and exaggeration. According to Magnan and Sérieux, the sweat may be secreted more abundantly on the face, or sometimes on one side of the body. Mickle has reported three cases of unilateral hyperidrosis. According to Gilbert Ballet and Paul Blocq, however, the modifications of secretion had nothing characteristic, and Mendel did not admit anything peculiar in them, as the

phenomenon occurred in healthy people. Six of the author's fifty-four patients were affected with hyperidrosis; in two of them it was of three months', and in three of two months' duration. In one it was exclusively limited in the second attack to the forehead. In all of the six cases the hypersecretion of sweat was very intense and generalised; the patients were covered with sweat from head to foot. The maximum of hypersecretion is found in the second period of general paralysis, or stage of depression; it was not noted in the mixed form nor in the form of remission, and occurred nearly as often in the calm as in the agitated state. Etiology does not have a great influence; the paralytics who were most affected were neither syphilitic nor alcoholic. The frequency and duration of hyperidrosis were in inverse proportion to the age of the patient; it was never observed after fifty. Contrary to expectation, it was twice as frequent in winter as in summer, and was not observed during the intermediate seasons. It was associated with all degrees of alteration of motion, but more particularly with moderate motor troubles. Finally, the hyperidrosis is always excessive at its onset, and ends abruptly.

S. E. DORE.

NOTE ON A NEW APPLICATION OF LIGHT IN THE TREATMENT OF LUPUS ERYTHEMATOSUS. NORMAN WALKER. (*The Scot. Med. and Surg. Journ.*, June, 1903, p. 513.)

RECENTLY Dr. Norman Walker has been trying the effects of exposures at a distance of about a foot away, from a London Hospital modification of the Finsen lamp, for the treatment of Lupus erythematosus. His idea was to obtain the effects of the light alone without the pressure, and it was suggested to him by a student who suffered from Lupus erythematosus, and who declared that the condition of his face invariably improved after exposure to the glare from the water when fishing in the Highlands. Exposures of from twenty to thirty minutes were employed daily or on alternate days in a number of cases. Six or eight exposures were required before any change was noted. "Some of the cases have been brilliantly successful, and all have shown improvement." The writer has been combining this treatment with applications of adrenalin chloride 1 in 4000, which seems to aid in the cure.

J. M. H. M.

ON A CASE OF ACUTE LYMPHATIC LEUKÆMIA WITH NUMEROUS SUBCUTANEOUS LYMPHATIC NODULES. J. LINDSAY STEVEN. (*Glasgow Med. Journ.*, July, 1903, p. 1.)

THE case described in this paper is a characteristic case of acute lymphatic leukæmia. It occurred in a van driver, aged 19, and terminated fatally about a week after admission into the Glasgow Royal Infirmary. The history of the illness and the clinical appearance of the patient, together with the blood examination, left no doubt as to the nature of the case. "The most striking feature on inspection of the anterior surface of the skin was the appearance of a number of small, rounded, steel-coloured nodules, about twelve in all, varying in size from a millet-seed to a threepenny-piece, and irregularly distributed over the surface. These nodules were in the skin, and could be felt as little tumours between the finger and thumb, and had all the appearance of multiple melanotic

sarcoma of the skin." There was distinct enlargement of the axillary and inguinal glands. A microscopical examination of the cutaneous nodules showed that they were composed of dense collections of mononuclear cells and connective-tissue fibres, separated by a diffuse lymphocytic infiltration.

J. M. H. M.

RADIO-PRAXIS. HENRY G. PIFFARD, M.D., LL.D. (*Medical Record*, New York, March 7th, 1903.)

IN the course of a survey of the present position of radio-therapy, the author gives a convenient comparison of the physical properties of the X rays and ultra-violet rays.

X rays.

1. Cannot be reflected, refracted, or polarised.
2. Can penetrate and traverse many bodies that will not permit the passage of luminous rays, *e. g.* wood, aluminium, etc.
3. Will readily traverse the superficial tissues, and influence the nutrition of deeper ones.
4. Will traverse a thick book.
5. Have no appreciable effect on bacteria.
6. Will discharge an electroscope either positively or negatively electrified.
7. Will excite bright green fluorescence in Willemite, and induce white phosphorescence in polysulphide of calcium.
8. Rock salt is opaque to X rays.

Ultra-violet rays.

1. Can be reflected, refracted, and polarised.
2. Will not traverse many bodies that are perfectly pervious to luminous rays, *e. g.* glass.
3. Will not influence the deeper tissues, nor even the superficial ones, unless they are deprived of their usual blood-content, *i. e.* de hæmatised.
4. Will be stopped by a single leaf of the same book.
5. Will rapidly destroy the vitality of bacteria.
6. Will discharge an electroscope if electrified negatively, but not positively.
7. Will excite bright green fluorescence in Willemite, and induce blue phosphorescence in polysulphide of calcium.
8. Rock salt is transparent to ultra-violet rays.

Dr. Piffard has found the use of adrenalin, as suggested by Jamieson, of value in rendering the tissue anæmic. He introduces the adrenalin solution by cataphoresis.

He calls attention to the following points in the therapy of cutaneous diseases as requiring further elucidation :

1. Are the ultra-violet radiations as effective as the X rays in the treatment of superficial malignant lesions ?
2. Is the low-tension arc the most effectual means for generating the ultra-violet radiations, and whatever goes with them ?
3. Is the high-tension arc or condenser spark equal or superior to the low-tension arc in its therapeutic effect ?
4. Is the spark from a coil more effective than that from a static machine, or *vice versa* ?

5. Is the hyperstatic spark with its ultra-violet accompaniments equal in therapeutic efficacy or superior to other devices for the production of ultra-violet radiations?

J. H. SEQUEIRA.

A CASE OF EARLY PEMPHIGUS FOLIACEUS. MEYNET and RIBOLLET. (*Annales de Derm. et de Syph.*, March, 1903, p. 205.)

THIS is a careful observation of a case during six months. The patient, aged 49, was a single woman in poor circumstances. Up to eighteen years of age her health had been good. At this time she became chlorotic, and remained so for five years. After this time nothing was noticeably wrong with her. The menopause occurred normally at the age of forty-three. It is expressly stated that there was no rheumatic, gastro-intestinal, alcoholic, syphilitic, or nervous disorder. She had no children. The disease here discussed began in April, 1901, with an excoriation, which was supposed to be traumatic, of the skin over the lumbar region. A crust formed in the part, which fell off and re-formed continually, and much itching was experienced in this position. Nothing further happened until August, when a bullous eruption appeared, first in the lumbar region, and then on the right arm, thorax, abdomen, and face; finally on the lower limbs, and on the palms and soles. The bullæ slowly invaded the body in this way during six months. They were preceded by itching and localised burning, and appeared on normal skin, and were surrounded by a congestive areola. Each bulla lasted for about twenty-four to forty-eight hours, and then burst, shedding the contained fluid, which was usually turbid, and left a red surface which became rapidly covered with scales constantly renewed. The conjunctivæ and mucous membranes remained intact. There was no dyspnoea, diarrhoea, or troubles of swallowing—no symptom, therefore, of affection of mucous membranes.

She was admitted into the Antiquaille Hospital of Lyons. At this time (August, 1902) there was general redness with general desquamation, but no bullæ were visible. Beneath the yellow greasy scales there was considerable exudation, and the skin was infiltrated and thickened. The hair was thinned on the scalp, which was covered with scales, and also deficient on the eyelids and eyebrows; in other parts of the body the hair was nearly absent. No alterations in the nails were noted, except a lustreless condition and some transverse striation. There was a disagreeable smell from the body.

Examination of the viscera revealed no disease, and the only symptoms complained of were itching, which was very distressing, and an increased sensitiveness to cold. There was no loss of flesh, but she was very weak.

The urine passed in twenty-four hours averaged at this time a litre; it was acid, sp. gr. 1002, with much diminished output of urea and phosphates; a trace of albumen, but no sugar.

The examination of the blood showed 3,500,000 red to 6200 white corpuscles. Films, stained with hæmatein-eosin, showed 40 per cent. polynuclear neutrophile corpuscles, 45 per cent. mononuclear, and 15 per cent. eosinophiles.

In December the report of the urine was very similar to that given above. In January, 1903, the general condition was good, but the affection of the skin had not materially changed. The blood at this time showed 50 per cent. polynuclear, 14 per cent. large mononuclear, 26 per cent. lymphocytes, and 10 per cent. eosinophiles.

In February the blood report was 80 per cent. polynuclear, 2 per cent. large mononuclear, 6 per cent. lymphocytes, and 4 per cent. eosinophiles. The urine showed throughout a diminution of urea and phosphates, and constant traces of albumen. It was distinctly scanty in quantity also, never exceeding a litre per day, and sometimes for a month at a time being only half or three quarters of a litre.

A remarkable feature was the general fair health of the patient during the two years that the disease had lasted.

Histological examination demonstrated inflammatory cell-infiltration in the inter-papillary zone of the corium. There was no appearance of the epidermal vesicle seen in pemphigus, but clefts, not filled with exudation, occurred frequently immediately beneath the epidermis.

E. GRAHAM LITTLE.

FURTHER EXPERIMENTS WITH ATOXYL. WALTHER SCHILD.
(*Dermatologisches Zeitschrift*, Bd. x, p. 35.)

THE dose of this preparation (meta-arsenious-anilide) is three grains in the form of a 20 per cent. injection given every third day. Such doses have been given for many weeks without causing any symptoms of intoxication, so that one is thereby able to give an amount of arsenic in atoxyl equivalent to ten times the amount possible in the form of arsenious acid. The cases quoted show that psoriasis was cured with eight to twelve injections, but local treatment was also used. Acne necrotica failed to respond, while pemphigus showed a cessation of the formation of bullæ. Seventeen cases of Lichen ruber also showed completely favourable results. Of three cases of Dermatitis herpetiformis, two yielded at once and remained three or four months without relapse, while the third was still under treatment.

A. W.

**DERMATITIS FOLLICULARIS ET PERIFOLLICULARIS CON-
GLOBATA.** SPITZER. (*Dermatologisches Zeitschrift*, 1903, Bd. x, p. 109.)

UNDER this resounding title is reported one of those curious instances of a syndrome well described by Lang in his text-book under the heading of comedones. The patient was a weaver aged 24, who had always been quite healthy up till 1899. He then went on service as an infantryman, and while serving his time the disease began, first on the back, as red nodules the size of a lentil, and unaccompanied by pain. They ruptured and discharged pus, but later deeper and larger nodes appeared upon the buttocks, and some of these discharged while others resolved without opening. In January, 1900, a node as large as a hazel-nut appeared on the neck and was surgically opened. More continued to appear on the neck, back, and head, until gradually the disease became disseminated. On admission the patient showed a striking appearance (a photograph is given in the text), being covered from head to foot with lentil-sized to palm-sized infiltrated nodules and patches of disease. They could be observed to begin as pin-head-sized nodules of a bluish colour, and some at least had central comedones, though they were not found in all. Without pain or any symptom of acute inflammation they grew to the size of a bean, when they softened in the centre. The skin gave way usually in more than one place over them, and a brownish

mass containing detritus was discharged. Microscopically this proved to contain numerous pus, epithelial, and giant cells. In many cases the lesions became grouped into flat infiltrations which discharged from many holes on pressure, and double comedo with comedo scar was frequent. On the back of the head the lesions differed slightly, the skin showing undermined, branching, suppurating cavities overhung by thickened and fibromatous scar, not unlike *Dermatitis papillaris capillitii*. The axillæ were somewhat similarly affected, and suggested *scrofuloderma*. On the body on several patches there were bridges of healthy skin which had been isolated by the burrowing and conjunction of two neighbouring lesions. In addition to these symptoms there were very numerous large scars surrounded by pigmentation, and suggesting those left by gummata. No evidence of any constitutional disease was found. The bacteriological examination of the aseptically collected contents gave *Staphylococcus albus* on cultivation, and a few cocci only were discoverable in stained sections. The histology was that of acne nodules, and in some instances showed those suppurating accumulations in the sebaceous glands familiar to all as a complication of nodose acne.

A. W.

IRON-LIGHT. EXPERIMENTAL AND CLINICAL RESEARCHES.

KROMAYER. (*Dermatologisches Zeitschrift*, Bd. x, p. 1.)

THE idea of this paper is to prove that the use of blue screens, fluid or solid, are of great use in the treatment of lupus by means of the arc light.

Kromayer starts with the statement that according to the reaction produced the "Dermo" lamp is thirty to forty times as powerful as the original Finsen lamp. According to this observer, the disadvantage said to lie with the iron electrode lamp—namely, that it does not penetrate—is owing to the fact that the enormous richness in ultra-violet rays renders the exposure necessarily short. He states, what is now generally admitted, that these ultra-violet rays are very easily stopped, and that the chief deep action of the light lies in the visible rays of the more actinic end of the spectrum. In order to exclude these ultra-violet rays, which cause such severe superficial reaction, he used solutions of methylene blue of varying strengths, or he painted the skin with methylene blue or methyl violet. The result of this modification was to immensely diminish the reaction and thus allow a much longer exposure. (The cases quoted are certainly not a high testimonial to this method of treatment, as in no case was a definite cure obtained, and in some instances the results were distinctly bad.)

A. W.

LICHEN RUBER ACUMINATUS IN A THREE-YEAR-OLD BOY.

HELLER. (*Dermatologisches Zeitschrift*, 1903, Bd. x, p. 153.)

THE subject of this report was a child of three years, who had been healthy up to two years previously, when his mother had noticed a scaly patch on one knee. In December, 1901, he was attacked by some febrile disorder, which his mother believed to be measles on account of the accompanying eruption; but this did not disappear, and slowly developed into the skin disease with which he was admitted in March, 1902. The eruption then consisted of single papules in the skin of a cinnabar colour and a peculiar wax-like transparency. Each had a little horny *button* on the top, and they tended to run into sheets, and then

developed a thick horny covering not unlike psoriasis. On the head there was a thick adherent scale, and there was some hair-loss resulting. The forehead was like the scalp, the most typical eruption being seen on the neck and the back of the lower part of the trunk. The thighs were less affected, and the knees were covered with the psoriasiform patches. The palms and soles were much thickened and desquamating, and the nails were very hard and brittle. The treatment was the inunction of a carbolic and mercury ointment into some places for the relief of itching, and the cautious application of a chrysarobin traumaticin to limited areas. The results of this were not striking; on the other hand, careful dieting, with a stay in the country and plenty of fresh air, was of great benefit. In June, 1902, he had a slight relapse, which yielded to treatment. The histology is only briefly dealt with, and corresponds to that already described by other authors, with the exception that Heller found a considerable infiltration into the papillary and subpapillary layers. This is, of course, described by some, and he suggests that it may vary with the stage of the disease.

A. W.

IRON ARC-LIGHT AND CONCENTRATED CARBON LIGHT.

GUNNI BUSCK. (*Dermatologisches Zeitschrift*, 1903, Bd. x, p. 178.)

THIS paper is an answer to that in the previous issue by Prof. Kromayer.

The author begins by traversing the original statement on which Kromayer's work is based—namely, that the Dermo lamp is thirty to forty times as powerful as the Finsen lamp when judged by reaction of the skin. Busck found by experiment that the following exposures were required to bring on a commencing erythema of the skin with the various lamps:—Carbon arc, current 80 ampères; at usual working distance, eight seconds. Bang's lamp, current 8 ampères; at usual working distance, ten seconds. Dermo lamp, current 5 ampères; at usual working distance, forty seconds.

He goes on to point out that the great length of exposure of the Finsen lamp is not to obtain reaction, but because one can thereby obtain a deep action, and that at the Finsen Institute the prevailing belief is in a directly bactericidal action combined with one detrimental to the life of pathological cells.

Experimentally it was found that *Bacillus prodigiosus* was unaffected by an exposure of five minutes to the Dermo lamp through a screen of methylene blue in a strength of 8 in 100,000 (that recommended by Kromayer), whereas by a 70-ampère carbon lamp they were killed in less than one second. Silver chloride paper, protected by two bloodless rabbits' ears, was totally blackened in three to four seconds with the 80-ampère lamp, while the iron lamp, working at 14 ampères, required three minutes. Chloride paper is hardly affected by light rays at the less refrangible end of the spectrum, and therefore this proves that Kromayer's apparatus works with roughly $\frac{1}{10}$ of the blue-violet rays possessed by the Finsen. (These papers agree closely with some unpublished experiments carried out by Prof. Jackson and myself at King's College in the autumn of 1901. We were then trying the effect clinically of the condensed spark, since brought out as a form of lamp. We found that although very rich in ultra-violet rays, almost the whole of these rays were intercepted by a slice of a callosity from one of our hands of the thickness of a thumb-nail, or by a portion of thumb-nail itself. Clinical observation also showed the same restriction to the surface, and the method was therefore not further pursued.)

A. W.

AN X-RAY ULCER BECOMING EPITHELIOMATOUS. (*Münch. med. Wochensch.*, No. 24, 1903, p. 1048.)

IN a discussion on the action of the X rays on epithelial tissues, especially carcinoma, at the 32nd Congress of the German Surgical Society, Kümmell, of Hamburg, called attention to a case in which an ulcer produced by the X rays became epitheliomatous, which necessitated the amputation of a limb. (No details apart from the foregoing.)

GEORGE PERNET.

REVIEW.

INTRA-MERCURIAL INJECTIONS IN SYPHILIS.*

IN a book of some 300 pages, Dr. Lévy-Bing describes his personal observations of the effects of 6000 intra-muscular injections made on 500 patients in the St. Lazare Hospital. As he has no serious accident to record he claims for this method that it should be considered *la méthode classique*, suitable for all stages of the disease, whether acquired or hereditary, for all ages, and especially for those debilitated by tuberculosis, etc. The cure is an intermittent one, consisting of four courses the first year, three each the second and third years, and two in the fourth year; the duration of treatment being thus at least twice as long as is the continuous oral treatment so generally adopted in England. As a preliminary to this method of treatment, the patient's weight, general physique, and the conditions of the mouth, urine, and kidneys, should be carefully investigated.

Two of the most interesting chapters in the book are devoted, one to the consideration of the equivalency of mercury in the preparations in use—as the authors says, a *most* important question and one too often neglected,—the other to the action of mercurial injections on the economy, including absorption and elimination, and their action on the blood. Mercury exists in the organism, not, as was formerly supposed, as a chloride, or later as an albuminate, but as metallic mercury in a very fine state of division.

Details of technique of the little operation should be most carefully observed, together with the strictest antiseptic precautions.

The preparation to be injected should have a definite chemical constitution, should be easy of preservation, readily soluble in water; or if an insoluble salt be used it should be one readily attacked by the fluids of the organism, yielding to them the products of its decomposition in a soluble form. It should give no precipitate with the substances contained in the fluids of the organism. It should be but slightly toxic—cause no pain, abscess, or induration. The preparations should have no addition such as morphia or cocaine made to them. Cocaine may lessen the primary, but has no effect on the secondary pain; and more, it decomposes certain mercurial preparations, giving rise to precipitates.

A set of iridium-platinum needles, of lengths varying from 5 to 7 cm., should be kept; the length of the one to be used depending on the thickness of the layer of fat of the buttock, the seat of election for these injections. Of the syringes

* Lévy-Bing. Paris.

recommended, the all-glass one of Lüer for soluble salts, of Feulard or Mathieu for the insoluble salts, and Barthélemy's for the gray oil, are the best.

Soluble injections are made daily for a series of twenty or thirty. This is often very inconvenient to patients, but mercury having a cumulative action, any untoward symptoms, such as stomatitis or diarrhoea, are more easily controlled than with the insoluble preparations which are given once a week. Among the soluble preparations the best results were obtained with the biniodide, the benzoate, the lactate, and the neutral salicylate.

With the insoluble compounds, the injection should be made in two stages, in order to be sure that no blood-vessel has been wounded. Calomel is undoubtedly the best, but gives rise to too great pain, and should be kept for very urgent cases. For ordinary use the gray oil and the basic salicylate are perhaps the most satisfactory.

A. SHILLITOE.

TO ILLUSTRATE DR. ARTHUR HALL'S CASE OF HERPES WITH OCULAR PARALYSIS.

THE BRITISH JOURNAL OF DERMATOLOGY.

SEPTEMBER, 1903.

HERPES OF LEFT UPPER DIVISION OF FIFTH NERVE
WITH OCULAR PARALYSIS; PARALYSIS OF RIGHT
THIRD NERVE WITH IRITIS; DIABETES.

BY ARTHUR HALL, M.A., M.B.CANTAB., M.R.C.P.,
*Physician, Sheffield Royal Hospital; Professor of Pathology, University College,
Sheffield.*

THE following case was kindly transferred to me by my colleague, Dr. Stanley Riseley, Ophthalmic Surgeon to the Sheffield Royal Hospital, under whose care it first came. For this and his valuable reports on the ocular conditions I am very grateful.

J. R—, male, aged 66, an iron moulder, was admitted into the Sheffield Royal Hospital on March 23rd, 1903, with complete paralysis of the left third and fourth nerves. He stated that eight weeks previously he was seized with very severe pains in the left side of the forehead; shortly after this an eruption appeared over the left side of the forehead and down the same side of the nose, with intense pain in the left eyeball. The eruption consisted of blebs, which burst and mattered, and when they healed up left scars behind. Shortly after the appearance of the eruption he found he was unable to open the left eye, and that when he pushed the lid open he saw double.

He first came up to the hospital on March 14th, when he was seen by my colleague, Dr. Stanley Riseley, who reports as follows:—"He is suffering from paralysis of the left third and fourth nerves, and congestion of the conjunctiva below. He has a nebula on the cornea,

down and in, which is, I think, old. There is ptosis, dilatation of pupil, and the eye is turned outwards. There is no action of muscles except the external rectus."

On March 21st he was again seen by Dr. Riseley, and complained that two days previously he had severe pain in the right eye, and inability to see properly or open his eye fully. He had then partial paralysis of the right third, together with iritis on the same side.

There was thus at that time complete paralysis of the left third and fourth nerves, with partial paralysis of the right third and iritis of the right eye. On March 23rd, when the patient was admitted to hospital, the paralysis of the right third nerve had entirely disappeared, and the only remaining lesion was the original paralysis of the left third and fourth nerves. There were also about half a dozen scars on the left side of the nose (nasal branch of fifth) and in the distribution of the supra-orbital branch on the forehead. These can be seen in the photograph.

A general examination of the patient showed that none of his organs were distinctly abnormal, except that the urine (sp. gr. 1028) contained a trace of albumen and 4.5 per cent. of sugar. There was, however, no polyuria and no thirst, nor was there any wasting. The knee-jerks were present, though diminished.

Dr. Riseley kindly reported on the eyes on March 26th as follows:—"Right eye now normal; no iritic adhesions. Fundus normal; V. $\bar{c} + .5 = \frac{6}{8}$. Left eye: still redness of conjunctiva below, with a papule. Cornea not anæsthetic; pupil regularly dilated. In lens are some cortical opacities, striated. Fundus normal. V. $= \frac{1}{1\frac{1}{2}}$, but is very dizzy when right eye is covered. On pointing at an object with right eye uncovered he does it easily, but cannot point directly at an object with left eye uncovered." The further history contains very little of importance. On April 15th he could half open the left eye, but there was still no further action of the ocular muscles. On April 20th the eye could be still further opened, and the movements of the ocular muscles were improving. He was discharged on April 24th, 1903.

On May 5th the paralysis had practically disappeared, but the inflamed papule on the lower conjunctiva still remained. During his stay in hospital the carbohydrates in his diet were reduced, and the sugar diminished to 3.5 per cent.

In recording this case it must be remembered that the actual herpetic eruption was not seen by either Dr. Riseley or myself. But from the very evident scarring (*vide* figure) over the distribution of the upper division of the fifth nerve, and the history of the intense pain preceding and accompanying the eruption, there can be no doubt as to its nature. An associated paralysis of the third and fourth nerves on the same side has been several times recorded in these cases of Herpes ophthalmicus. When we come to the intercurrent attack of paralysis of the *right* third nerve, together with severe pain and iritis, all of which passed off in a few days without any herpetic eruption, there is introduced an element of considerable interest. Cases of bilateral Herpes zoster are not unknown, but I am not aware of any record of a Herpes ophthalmicus with associated paralysis on one side being followed by paralysis without herpes on the opposite side in the same area. The explanation seems to be that the patient is suffering from diabetes. As is well known, in this disease it is not uncommon for paralysis of ocular nerves and iritis to occur, probably as the result of a toxic neuritis. Such was probably the cause of the right-sided intercurrent paralysis, and possibly also of the herpes and paralysis of the left side. It is curious, however, that whilst neuritis in various parts is not uncommon in diabetes, yet herpes in any form apparently is.

SOME OBSERVATIONS ON SMALLPOX.

By LESLIE ROBERTS, M.D.,

Dermatologist to the Liverpool Royal Infirmary.

EARLY in the winter of 1902 I was consulted by a man for an eruption which had appeared on his face three days previous to his visit to the Royal Infirmary. The lesions, of which there were hardly more than a dozen, had the aspect of solid growths. They were nodular in shape, had smooth contours, and were not umbilicated. They looked not unlike the lesions of Adenoma sebaceum. When pricked nothing issued but a little blood; there was certainly no pus, and no hyperæmic reaction. The face was pale. Three days before

the eruption appeared the man felt ill, and for a day took to his bed. I made no diagnosis on his first visit, but the difficulty was soon cleared up, and the patient was admitted to the smallpox hospital. It was a case of variola highly modified by remote vaccinia.

This remarkable, but by no means singular case, occurred at the beginning of a very extensive epidemic of smallpox which passed over certain parts of Liverpool last winter. Through my failure to diagnose this form of variola I became conscious of a defect in my dermatological training. In none of the clinics abroad or at home had I seen an example of variola. And present-day authors of dermatological treatises, trusting to the final extinction of this dread pest, have either omitted it altogether from the list of cutaneous diseases, or, if they referred to it at all, a few perfunctory paragraphs sufficed for its description. But variola is not extinct, and, fostered by foolish legislation, it will once more become an active disease. Since the beginning of the winter of 1902 nearly 1800 cases of smallpox have passed through the hands of Dr. N. E. Roberts, the physician to the city fever hospitals; and thanks to his obliging courtesy, I was able to avail myself of the rare opportunity of studying the disease in its epidemic form.

I shall not essay in this brief article any formal description of variola. It has been admirably done by such masters of dermatology as Hebra, Anthony Todd Thompson, Erasmus Wilson, and Tilbury Fox, not to speak of the great medical writers of the early decades of the nineteenth century. My present purpose shall be confined to the simpler task of noting one or two points which a physician not specially familiar with cutaneous pathology might overlook, and which struck me forcibly, looking at the cases from the standpoint of a dermatologist.

POST-VACCINAL VARIOLA.

The older observers recognised these modified cases as forming a distinct class, which Dr. A. T. Thompson called post-vaccinal variola. They were referred to in the old text-books as *Variola verrucosa*, *Variola cornea*, wart-pock, horn-pock, stone-pock. I saw many of these acneiform cases of variola, which the old German authors would have called *hornpocken*, in which the lesions were confined to the face,

and which had so little of the variolous aspect that, regarded by themselves apart from the history and the fact that they came from a variola-infected house, their true nature would never have been suspected even by an experienced dermatologist.

In one of the wards I saw a man about fifty years of age. He appeared to be in good health, and answered our questions with a degree of energy which did not suggest any serious constitutional disturbance. The scalp and face were seborrhoic, the follicles dilated, and the capillaries were in the condition seen in mild rosacea. Scattered over the face were a few hard papules, having the aspect and dense, firm consistence of small nodular tumours. I noted specially the absence of pus, and had it not been for the fact that he came from an infected street it would hardly have been possible to make a certain diagnosis. The medical superintendent assured me that there was no doubt as regards the variolous nature of the case, and his opinion was corroborated by the negative result of vaccination.

I observed this facial modification of the variolous lesions in a young man aged 21, who had not been vaccinated since infancy. His body and limbs were universally covered with the typical smallpox pustules. The lesions on the face were so numerous as to completely occupy the whole of the facial surface, and had an entirely different aspect from the lesions elsewhere. They were broad, flattened, slightly elevated tumours of a dull red colour. Each of these tumours had arisen from its own centre, and was separated from the contiguous tumours by shallow grooves. There was no pus in the face lesions. Such cases as these, in which the lesions of the face differed notably from the variolous lesions in other parts of the body, occurred from time to time. Out of a batch of, say, 100 cases of smallpox, the acneiform variety would occur two or three times. There is certainly some tissue influence which modifies the evolution of the variolous lesion, and I believe it is co-existing seborrhœa. Those individuals in whom the horn-pock was best marked were seborrhoic at the time when they became infected with variola.

I was struck by the resemblance presented by the variola pustules to Herpes zoster vesicles. The tendency for the lesions to run in curved lines and to develop in clusters is common to both these diseases. And again, their mode of fusion with adjacent lesions

forming a corymbiform efflorescence is not less conspicuous in variola than it is in Herpes zoster. I think the likeness may be carried further than this; for by observing the extension of variolous lesions over the cutaneous surface in a large number of consecutive cases, I cannot resist the conclusion that one of the major influences which governs the extension of the disease issues from some central nervous mechanism. The evolution of smallpox is so deliberate; its descent from the head, its steady flow outwards to the remote parts of the body so steady, so regular, often so swift; the repetition of its lesions so mathematically uniform (unless where modified by special causes), that I cannot but see in these phenomena the evidence of some force, probably of central nervous origin, which controls the distribution of the disease.

But while it is probable that the general development of cutaneous lesions in smallpox is controlled by a central nervous mechanism, it is quite certain that variations in the intensity of the development of the eruption are produced by external causes, and also by the degree of irritability of the skin itself. Thus Hebra had often observed that the irritation provoked by garters or corsets would determine an extra development of lesions in the irritated site. Indeed, Hebra went so far, if I remember rightly, as to say that one could sometimes guess the occupation of the patient from special variations in the development of the variolous lesions.

I saw two cases which illustrated this principle. The first was that of a young woman who had been subject to repeated attacks of Herpes simplex on the left cheek. The variolous pustules developed in semi-confluent masses in this herpetic area, while only a few pustules were to be found in other parts of the body. The second case was that of an adult woman who had been vaccinated while incubating smallpox; the vaccine pustules formed perfectly, and in the near neighbourhood of the vaccine pustules I noted an unusually rich development of variola pustules, elsewhere the eruption being sparse and discrete.

This leads me to another point of great theoretical as well as practical interest. Can two morbiferous viruses incubate simultaneously in the same body? The answer to this is in the affirmative. I saw cases in which the whole body was covered with variolous pustules from head to foot, in which typical vaccine pustules had

formed on the arm. Clinically the lesions of these two morbid processes can be distinguished by the free superficial suppuration of vaccinia and the early neoplasmod character of the true variola lesions. The dualism which is so striking a feature in the life-history of these two processes is rendered possible by the fact that the individual inoculated with variolous poison becomes immunised more slowly than the same, or any other, individual inoculated with vaccine matter. Thus, to quote from my friend Dr. N. E. Roberts, the immunising period of vaccinia is nine days, while the immunising point of smallpox is probably not attained until about the eleventh day of the disease—a good three weeks after the disease was contracted, allowing twelve days for incubation. Hence, if an individual contracts the two diseases, variola and vaccinia, on the same day, he will manifest in due time vaccinia, but not variola. If he be vaccinated on the second day after variolous infection, he will develop vaccinia, but not variola. If he be vaccinated on the third day he may still be protected by vaccinia; but if the vaccination be delayed till the fifth or sixth day after variolous infection, the variola will develop *pari passu* with the vaccinia. It is proved now to the point of demonstration that an individual who has incubated variola, and has actually developed the smallpox eruption, is not protected against vaccinia *until a certain time* has lapsed. Dr. N. E. Roberts cites the case of a nurse from one of the general hospitals who was vaccinated forty hours after the variolous eruption had broken out, and yet in this case vaccine pustules developed. This is certainly remarkable, but I have reason to believe that even forty hours is not the extreme limit. The lesson we can learn from this is that the obscure cellular processes by which immunity is brought about require many days to be safely realised, and that the immunising process is certainly longer for variola than it is for vaccinia.*

Another point of no small importance is that the child of a mother affected with smallpox may be inoculated *in utero*. A married woman was admitted to hospital on December the 13th, and three days later (the 16th) was delivered of a child, which was vaccinated on the 17th. In this case vaccination appeared to be successful, but on the eighth day of vaccinia—that is, on the 25th December—the onset of variola was noticed in the child, and on the 27th the eruption

* *N.B.*—Dr. N. E. Roberts's observations on these points will shortly be published.

appeared. The child therefore contracted smallpox twelve days before the 25th December *in utero*, *i. e.* three days before birth.

The following case presents a contrast to that which I have just cited. A child was born just one day before the mother was admitted to the smallpox hospital. The child was vaccinated immediately. In this case the mother was covered with smallpox pustules from head to foot, but her infant remained well in spite of contact with the mother. The vaccination had just been in time.

My last note relates to the general character of the variolous eruption. I have already mentioned the fact that the eruption is a descending one. This I believe is invariable, and the descent is, in the vast majority of cases, from the scalp or the upper part of the head. The eruption may appear almost simultaneously on the face and hands and forearms, but then we know how close is the nervous relationship between the hands and face. But apart from the apparent skipping, the spread of the disease over the body is so regular as to suggest comparison with a tidal wave proceeding from a focal centre of disturbance, and travelling outwards to the calm beyond the boundary of disturbance. If the whole blood of the patient is equally infected with the variola organisms, how is it that the development of lesions in the skin progresses from one end of the body to the other, and always in the same direction? Before we can answer this question we must know something of the laws which govern the distribution of rashes and eruptions in general, and of those we know very little at present.

There is a striking uniformity in the method of formation and retrogression of the smallpox lesion. If we suppose the body to be divided into transverse planes, we may say as a general truth that all the lesions in any one plane are in the same stage of development. In point of time the lesions on or near the head are always in advance of those on the trunk, while those on the trunk are more advanced than those below the pelvis, and still more in advance of those near the feet. This, I should say, is one of the most notable of all the diagnostic features of smallpox. There appears to be no exception to this law, and so striking is it that it conveys to the mind the impression that nature is working on a single uniform plan. The lesions appear to be moulded on one common pattern. If morphological variations do appear, they are due to influences

which involve whole regions, as, for example, seborrhœa of the face, and gravity and remoteness from the centre of the circulation, the effects of which are seen in the hæmorrhage into the lesions on the soles of the feet.

The smallpox lesion appears to pass through the macular, papular, vesicular, and pustular stages, but even in the evanescent macular stage the lesions are composed of dense infiltration. In one sense the terms *vesicular* and *pustular* are misnomers as applied to the lesions of variola, for the vesicles are never simple cavities in the epithelium filled up with fluid, and the pustules are never simple cavities filled up with pus. Indeed, the formation of pus is an accident which befalls the lesion, and, as Finsen has demonstrated, the accident may be avoided by the total exclusion of blue and violet and ultra-violet rays from the room in which the patient lives. Under ordinary circumstances, however, the lesions terminate in suppuration. But it is not impetiginoid suppuration. It does not consist in a loose collection of leucocytes around a microbic focus. The maturation of the lesions of smallpox which correspond with the advent of the "secondary fever" on the seventh day, is in reality due to the sudden breaking down of the dense cell-infiltration masses impacted within the epithelium. It is during the period of breaking down of the lesions, when so many toxins and irritating agents are liberated, that so much local as well as constitutional disturbance is liable to arise. This is the time when the lesions are surrounded by a red areola, when the eyes become closed and the lips swollen by œdema, and when most pain and distress are experienced by the patient. If by adopting Finsen's method of excluding blue light we can prevent this sudden dissolution of the original dry lesion, we should certainly rob smallpox of its greatest terror.

LABIOMYCOSIS.

By WILLMOTT EVANS, M.D., F.R.C.S.,
Surgeon to the Skin Department, Royal Free Hospital.

THERE are doubtless many different conditions included under the general term of patchy eczema of the face, and some of them have

been already differentiated ; but, so far as I am aware, the special form described below has not hitherto been specially noticed.

The close proximity of the lips to the mouth would of itself make it extremely probable that an infection might spread from the buccal mucous membrane to the adjoining cutaneous surface ; and, indeed, every one has many times seen that an ulceration of the mucous membrane of the mouth has been accompanied by a similar affection of the neighbouring skin, though the lesions may not have been identical in appearance, the difference being accounted for by the different structure and condition of the mucous membrane and the skin.

The mouth in health contains a large number of micro-organisms, which may be called the "normal" inhabitants of the buccal cavity ; and in addition to these there are many occasional micro-organisms. In a healthy condition of the mucous membrane they do not give rise to any morbid appearance in the mouth ; yet some of them may readily set up an inflammation of the adjoining skin if the conditions are favourable. As a rule the skin of the lips is too dry to permit the growth of any of these micro-organisms ; but if the labial skin be unduly moist it is obvious that the conditions will be much more favourable for the development of these buccal bacteria. This requisite moisture is most readily supplied from the mouth by the tongue, and therefore any morbid condition arising from such an infection is far more likely to be observed in children than in adults, for children are much more likely to lick the lips with the tongue.

In April, 1898, I saw in my out-patient skin department at the Royal Free Hospital a little girl, 5 years old ; she was well-nourished and in good health. For about two months she had had an eruption round the mouth affecting both the upper and lower lips. The cutaneous surface only was affected, the mucous membrane being perfectly healthy. The skin was reddened in two crescentic bands, one on each lip, lying parallel with but at a distance of $\frac{1}{8}$ inch from the muco-cutaneous margins. The patch on the lower lip was about $\frac{1}{4}$ inch in width, and decidedly longer and wider than that on the upper lip. The surface of the reddened patches was rough and scaly, and it was a little sore. The child's mother said that the condition had been much worse than when she was brought to me, and she attributed the disease to a practice the child had of continually licking her lips ; for when by persuasion the mother induced

the child to refrain from licking her lips, the condition improved. While the child was under examination she frequently put out her tongue to lick the inflamed surface, and it was then noticeable that the tip of the tongue extended just as far as the distal edge of the patches. The mouth and tongue when examined were found to be perfectly healthy, no ulceration or soreness being present. A scraping of the scaly surface was taken and examined microscopically; it was found to contain among the epithelial scales a large amount of mycelium. The tubes which formed the mycelium were of large calibre, measuring 6 to 10 μ in diameter. The mycelium was non-septate, and no trace of sporulation of any form could be seen. The great amount of the mycelium in the lesion appeared to me to render it practically certain that the skin affection was the effect of the presence of the organism, and that the latter was not merely a casual denizen in the diseased tissue. Attempts at cultivation of this organism were not very satisfactory. The condition had, according to the mother's account, already commenced to improve when I first saw it, and a few days' application of the Unguentum Hydrargyri Ammoniati was followed by the complete disappearance of the eruption; the white precipitate acted probably not only as an antiseptic, but also by preventing the moisture of the tongue from affecting the lips.

Since I saw this first case, I have seen about twenty other examples of the same condition, with the same organism present. In many other cases, less well marked, I have found only a scanty mycelium; but these cases probably belonged to the same class, or at least to an allied condition.

Undoubtedly this disease is likely to be called an "eczema" of the lips, yet it does not correspond to any of Dubreuilh's four classes of eczema of the lips (*Monatshefte für prakt. Dermat.*, vol. xiii, No. 8, 1891), unless it is included under his fourth class of seborrhoic eczema.

Justin Lemaistre has described (*Discours d'ouverture de l'École de Médecine de Limoges*, "De la perlèche et du *Streptococcus plicatilis*," 1885) a condition which he found extensively distributed amongst the children of the district of Limoges, for nearly six per cent. of the children examined manifested it. It affected the lips, causing them to become sore, dry, and cracked, and the children continually licked

their lips to relieve the smarting. It affected the mucous membrane rather than the cutaneous surface of the lips, and it was known locally as *la perlèche* or *le bridon*. Lemaistre found a streptococcus present, which he named *Streptococcus plicatilis*, and he attributed the disease to this, and thought it arose from infected drinking-cups and contaminated water. *Perlèche* has been described by several others, as by F. Jaja (*Giornale italiano d. mal. ven. et d. pelle*, 1887), Moretti (*Rivista clinica di Bologna*, 1886), P. Raymond (*Bull. de la Soc. de Dermatol. et de Syph.*, 1893, p. 289), and R. Plance (*Thèse de Paris*); and though they agree as to the clinical condition, there is the greatest diversity as to the etiology, but they reject the *Streptococcus plicatilis* as the cause of the disease.

Perlèche certainly resembles the condition I have described above in some respects, but it attacks the mucous membrane rather than the skin, and it would be absolutely impossible for any microscopist to miss the mycelium which is so obvious in my own cases. I cannot think that *perlèche* and the disease I have described are identical.

Saccharomyces albicans, the organism causing thrush, may also attack the lips, but it confines itself, so far as I know, to the mucous membrane, and does not invade the cutaneous surface.

T. D. Savill described in 1896 (*British Journal of Dermatology*, 1896, p. 27) a "perioral eczema" which occurred in an epidemic form in certain London primary schools; but though it is analogous, the description given differs in several important respects from the condition I have described.

What is the organism which I found in my cases? It is, I think, a hyphomycetes, but I have not been able to identify it with any of the described species. I think it is not improbable that it has been included under the somewhat elastic term of *Leptothrix buccalis*, but the typical *leptothrix* is a schizomycetes, and is much narrower than the form I am describing.

I think the disease is a distinct entity both clinically and etio-logically, and deserves a distinct name; at present I think *Labiomycosis* is the most suitable. The disease in a typical form is not common.

The treatment is extremely simple, the weakest antiseptic ointments sufficing to remove the disease in a few days. In this respect it markedly differs from most forms of *Eczema labiale*.

CLINICAL NOTE.

CASE OF ANGIOKERATOMA WITH CHILBLAIN CIRCULATION, ERYTHEMA PERNIO, AND BAZIN'S DISEASE.

BY S. E. DORE, M.B.CAMB.

THE following case was shown at the meeting of the Dermatological Society of London on April 8th, 1903. The patient had attended the Middlesex Hospital for a fortnight previous to exhibition, under the care of Dr. Pringle, to whom I am indebted for permission to record these notes.

Family history.—She knows very little about her father, not having seen him for several years. Her mother died young from an unknown cause. Four brothers and two sisters are living, and all are stated to have suffered with blue and swollen hands, but to a less degree than herself. There is no history of phthisis obtainable, nor anything suggestive of congenital syphilis.

History of present condition.—Her hands have been blue and swollen as long as she can remember. As a child her feet and arms are said to have been affected in a similar manner, but they have not troubled her since the age of ten. When she was about twelve years of age she had "ulcers" on her legs and a few on her arms. These were "like abscesses," and lasted for several months.

Present condition.—She is a spare, dark-complexioned, somewhat phthisical-looking girl of 18 years. She suffers from indigestion and constipation, and has not menstruated for eight months. Her tonsils are much enlarged and nearly meet in the middle line.

The fingers of both her hands are intensely cold, blue, cyanosed, and considerably swollen. The condition is more marked on the dorsal than the palmar surfaces, and does not extend above the metacarpo-phalangeal articulations. In addition to the general dusky cyanosis there are several areas of a brighter colour due to recent chilblains, which give the hands a mottled appearance, and one or two scars similar to those to be described on the legs. There are also numerous dark blue punctate lesions made up of aggregations of minute telangiectases, over which the skin is slightly raised and distinctly verrucose. These are situated on the dorsal surfaces and sides of the fingers, the greater number of them being on the

ulnar side. These lesions correspond accurately with that of angiokeratoma given by Mibelli, Pringle, and others, but the predominance of the telangiectatic over the keratotic element is of interest as indicating the method of development—namely, a primary increase of vascularity, followed by a secondary epidermic hypertrophy.

There is a considerable degree of hyperidrosis of the hands, the condition of which is aggravated by the constant use of water necessitated by the patient's occupation of housemaid-waitress.

The nails are thin and brittle, and longitudinally striated. The skin of the ears is scaly and superficially scarred, the condition closely simulating in appearance that produced by Lupus erythematosus. There is some congestion and cyanosis, with less definite scarring on the tip of the nose.

On the posterior aspect of the calves there are several circular, white, shiny, deep cicatrices with well-defined edges, characteristic or strongly suggestive of Bazin's disease, and several similar scars are seen on the hands and forearms. The feet present no obvious abnormalities, but cause her considerable pain and aching after standing.

Remarks.—Cases illustrating the association of angiokeratoma and chilblain circulation with various tubercular lesions have been reported by Colcott Fox, Galloway, and other authors; and the prevalence of tubercular manifestations in persons with so-called "poor" circulation is so marked that some observers have ascribed the acro-asphyxial condition to the circulation of the toxin of the tubercle bacilli. The fact that chilblain and its sequel, angiokeratoma, are often seen without any tubercular lesion militates strongly against the correctness of this hypothesis; and this patient would seem to bear out the view that the inefficiency of the circulation is a predisposing factor rather than a result of tubercular infection. From the history it seems clear that the acro-asphyxia was a precursor of any tubercular infection. Later definite lesions, which were almost certainly of a tubercular nature, made their appearance, but these healed, and there was no reason to believe that she had any tubercular foci when she sought relief at the hospital. The circulatory incompetence still remained, however, and thus appears to have been a persistent condition, which at one time was complicated with a mild form of tuberculosis.

REVIEWS.

TRANSACTIONS OF THE AMERICAN DERMATOLOGICAL ASSOCIATION.*

THE task of reviewing the official report of the proceedings of the American Dermatological Association is one of the most pleasant duties connected with the editorial work of our Journal. For several years this annual report may be fitly described as a mirror of the dermatological progress during the preceding year. The volume before us is no exception to the rule.

The annual meeting of the American Dermatological Association for 1902 was held at Boston under the presidency of Dr. George Thomas Jackson, of New York. As the subject of his presidential address Dr. Jackson chose the history of the Association during the first quarter of a century of its life, which was just completed at the time of the meeting. The story of the Society is interestingly told. It was organized in 1876, with Dr. J. C. White as its President, and the first annual meeting was held at Niagara Falls in the following year. A detailed account of the Society's work since its inception was given, and among the contributors of papers are the names of all the leading dermatologists on the other side of the Atlantic. The long list of books, pamphlets, and papers published by its members gives evidence of a vast amount of conscientious work accomplished during these years, and a great promise in the near future, and no one can read this list without a feeling of gratitude and admiration for the enthusiasm and energy there displayed in the study of dermatology.

The first paper at this the twenty-sixth meeting of the Association was read by Dr. J. S. Howe, of Boston, on *Cases of Bullous Dermatitis following Vaccination*. Ten such cases were described, six of which were fatal. The average duration of the disease in these cases was six weeks from the time the first skin lesion appeared, until death or recovery took place. The skin lesions began in an average of five weeks after vaccination. In all the cases the parts affected were the back and neck, the region between the shoulders, the axillæ, the buttocks, and the inner aspect of the thighs, and in these places there was a noticeable grouping of bullæ. Lesions were present in the mouth and pharynx. The writer discussed the important problem of the causation of the disease, and the name best applicable to it. He did not consider it to be the result of the vaccination itself, as, so far as he could learn, animal lymph from a trustworthy source was used in all these cases. Some years ago Bowen published a series of cases of bullous dermatitis following vaccination, which he thought were not improbably "due to a toxin developed by the vaccination in certain predisposed individuals." But Bowen's cases were all in children (while the cases here reported were in adults), none of them were fatal, and the trunk was free from eruptions and the constitutional disturbance was trivial. Though there was no actual proof, the speaker considered that the cutaneous manifestations were probably the result of infectious material introduced at or after vaccination. With regard to the name, he proposed to call them cases of pemphigus rather

* *Transactions of the American Dermatological Association*, September, 1902. Official Report of the proceedings. By F. H. MONTGOMERY. P. J. Pettibone and Co., Chicago.

than of Dermatitis herpetiformis. In discussing the paper During stated that he believed that the virus was introduced at the time of vaccination, and was not a subsequent infection, and he considered that the term "bullous dermatitis following vaccination" was well chosen. Stelwagon suggested the possibility of the virus being obtained from the animal from which the vaccine was procured, and that it might be of the nature of the virus of acute pemphigus. Dr. Nevins Hyde strongly disapproved of regarding the symptoms as due to vaccination, and considered with Bronson that they were most probably due to the introduction of some germ at the time of vaccination. Dr. Corlett, of Cleveland, stated in this connection that in his clinical experience—which is a very large one—he could recall only one instance of an eruption following vaccination, and it took the form of impetigo.

Dr. Wende, of Buffalo, reported a case of *Epidermolysis bullosa hereditaria* which presented certain unusual features. These consisted of marked infiltration of the skin after the lesions subsided, the arrangement of the bullæ into concentric lesions, decided changes in the nails, and loss of hair from the scalp, eyebrows, and eyelashes. The falling out of the hair, in addition to the characteristic lesions of epidermolysis, rendered this case most unusual, and brought it into line with the "Dystrophia unguium et pilorum hereditaria" described by Dr. C. J. White.

Dr. J. T. Bowen contributed a paper on four forms of *Generalised Exfoliative Dermatitis*. He took exception to what he called the English custom of considering all such cases as examples of Pityriasis rubra, and believed that there were different etiological agents at work in the various forms. Though the custom of labelling the majority of such cases as Pityriasis rubra (Hebra) may have prevailed till recently, it no longer does so, and it is now recognised quite as much here as in America that Pityriasis rubra is an exceptionally rare disease; and it has even been doubted whether such an entity exists, and has been suggested that the majority of all these generalised exfoliative cases are either of the toxic type (Erythema scarlatiniforme) or follow in the course of a severe attack of some other dermatitis, such as Eczema, Psoriasis, or Lichen planus.

Dr. Hermann Klotz read a critical paper on *Philipppson's Proposed Reform of Dermatology*. This paper has already appeared *in extenso* in the *Journal of Cutaneous and Genito-Urinary Diseases*.

Dr. Sherwell, of Brooklyn, read a short note on *A Case of Pellagra*, which was specially interesting owing to the rarity of the disease in the United States.

Dr. C. J. White, of Boston, contributed a statistical paper on the *Clinical Study of Four Hundred and Eighty-five Cases of Nail Disease*. To this are appended useful tables showing the relative proportion of the various diseases, their ages of incidence, and the type of lesions which occur. The largest number of cases he puts down to Eczema (107); then follow in order Trauma (74), Paronychia (68), Psoriasis (67), Professional Dermatitis (62), Syphilis (28), No apparent cause (9), Fevers (8).

Dr. F. J. Leviser followed with a contribution on the *Clinical Aspect and Treatment of some Affections of the Finger-nails*.

Dr. Isadore Dyer presented a report of a case of *Blastomycetic Dermatitis*, which occurred in New Orleans.

Dr. Pollitzer, of New York, read a note on the *Histology of Herpes zoster*.

On the second day of the meeting the subject for general discussion was *Acne vulgaris*. This was opened by Dr. T. C. Gilchrist, of Baltimore, who discussed the

etiology and pathology of the disease, and gave a careful historical account of the work of Unna, Hodara, Lowry, and Sabouraud on the subject, as well as his own observations with regard to the "*Bacillus acnes*." The symptoms and treatment were next described by Dr. G. H. Fox, of New York. This was followed by a lengthy discussion, which was taken part in by a large number of the members.

Drs. D. W. Montgomery, Howard Morrow, and Ryfkogel, of San Francisco, read a paper on their case of "*Coccidioides*," under the heading of "*Another instance of a Disease caused by a Fungus*."

Dr. F. H. Montgomery presented the history of a *Case of Cutaneous Blastomycosis, followed by Laryngeal and Systemic Tuberculosis, and Death*.

Dr. Nevins Hyde contributed an important paper on the *Dermatoses occurring in Exophthalmic Goitre*, to which a full bibliography is appended.

In the afternoon session of the second day of the Congress Dr. W. T. Councilman, of Boston, gave a lantern demonstration of the *Lesions of Smallpox, particularly those of the Skin*; Dr. Ravogli, of Cincinnati, gave a further report on *Nævo-carcinoma*; Dr. Charles Allen, of New York, read a paper, illustrated with lantern slides, on *The Value of Radiography in Cutaneous and other Cancers*; and Dr. Zeisler, of Chicago, read a paper entitled *Radio-therapeutic Observations*. The last-mentioned observer has employed the X-rays with varied success in *Lupus vulgaris*, *Lupus erythematosus*, *Scrofuloderma*, *Hypertrichosis*, *Sycosis*, *Acne*, *Epithelioma*, *Psoriasis*, *Eczema*, *Keratosis palmaris*, *Lichen planus*, *Clavus*, *Pruritus genitalis*, *Hyperidrosis nasi*, *Dermatitis staphylogenes*.

Dr. J. M. Winfield, of New York, presented a paper named *Dermatoses of the Insane: A Report of Patients of the Long Island State Hospital for the Insane*. An examination of over 1000 insane patients showed only 146 examples of skin disease, and some of this number were from external causes, or had been contracted before entering the institution. It showed that many of the statements of the alienists regarding the great prevalence of cutaneous stigmata in the insane were erroneous.

The third day of the Congress was devoted to the clinical demonstration of unusual cases of skin disease. Among the rarities shown were cases of *Angioma serpiginosum*, *Darier's disease* (*Psorospermiosis follicularis vegetans*), and *Parakeratosis variegata*, or *Erythrodermie Pityriasique en Plaques Disseminées*.

This short review, which does little more than mention the titles of the papers, and does but scant justice to the record of a year's hard work, if it does nothing else will show the excellent example of diligence on the part of our American *confrères* in dermatology, and may well serve as a stimulus to us all.

J. M. H. M.

PORTFOLIO OF DERMOCROMES.*

THE edition in German of Professor Jacobi's *Atlas* appears to have had a considerable degree of success, and Messrs. Rebman introduce it with the text in English. The illustrations represent a wide range of diseases of the skin, chosen more on account of their frequency of occurrence than on account of rarity;

* *Portfolio of Dermochromes*, by Professor Jacobi, of Freiberg. English adaptation of the text by Dr. J. J. Pringle. London: Rebman, 1903. Price:—Four parts, £2 10s.; bound in two vols., in half leather, £2 17s. 6d.; bound in flexible leather, £3 3s.

the majority have been obtained from models in Professor Neisser's clinic in Breslau, the handiwork of Mr. Kröner, though some come from other sources; the method of reproduction is by a four-colour process known as *citochromy*. Many of these reproductions are wonderfully successful, and as there are at least seventy-eight plates provided in the first two parts already published, sufficient opportunity is offered to judge of the capabilities of this method of colour reproduction. There can be little doubt that of the smaller atlases of dermatology this is the most successful, in spite of the fact that two mechanical processes at least have to be gone through between the representation of the skin diseases in these pages and the actual appearance of the patient. The *Atlas* will, we know, be welcome to many interested in dermatology who wish to have by them volumes of reference to assist their clinical experience.

The letterpress, as stated by Dr. Pringle, is really a subsidiary part of this undertaking; a short account is given of the various conditions illustrated, but no attempt has been made to supplement the necessary systematic treatises on diseases of the skin. It is in our minds to wish that Dr. Pringle could have seen his way to use his own experience in describing the large number of important diseases illustrated in the work under review.

MANUAL OF MEDICINE.*

IN this manual, which is primarily intended for students, the author has endeavoured to present a book which, while not so trivial as many of the smaller text-books on medicine, is yet more suitable to the needs of the student than the larger and more detailed classical treatises on the subject. Considering the size of the volume, which contains about 800 demy octavo pages of letterpress with large clear type, the work is exceptionally complete, and little is left out which the student should know. It is written in simple and concise language. About fifty pages of it are devoted to the discussion of the diseases of the skin, and it is with these pages that we are chiefly concerned.

After describing the elementary lesions of the skin the writer discusses the more common diseases which affect it. He adopts an unusual and, we hope, unique grouping and classification of skin affections in dividing them into (a) functional affections, under which heading are included such incongruities as Alopecia areata, Trichorrhesis nodosa, Comedo, and Miliun; and (b) organic diseases, which include inflammations, new formations, and diseases due to parasitic fungi.

We would strongly advise writers of manuals on general medicine to refrain from competing with the difficult problem of classification in dermatology, and to content themselves with an alphabetical arrangement.

Apart from this, the section on the skin affections is fairly adequately done, and will serve its purpose in introducing the reader to the more common cutaneous diseases.

The book is illustrated by a number of diagrams of the nervous system and heart, and a series of temperature charts.

* *Manual of Medicine*, by T. K. MONRO, M.A., M.D. London, 1903: Baillière, Tindall, and Cox. Price 15s. net.

HIGH-FREQUENCY CURRENTS IN THE TREATMENT OF SOME DISEASES.*

IN this handy volume of 218 pages the author begins by shortly referring to the history of the discovery of high-frequency currents, and to the work of Hertz, Lodge, D'Arsonval, and Oudin on the subject.

The source of energy is next discussed in a more or less elementary chapter on electrical batteries, accumulators, transformers, and static machines. Then follow chapters on the special apparatus necessary for the production of high-frequency currents and their physical and physiological properties. The method of applying them therapeutically is next described, and their value in the treatment of certain general and local diseases is discussed. Among the general diseases said to be benefited by high-frequency currents are gout, chronic rheumatism, anæmia, phthisis, atonic dilatation of the stomach, and diabetes; and among the local affections are Lupus erythematosus, psoriasis, warts, rodent ulcer, and a number of others. An ulcerated patch of Lupus vulgaris on the neck of a girl is reported to have disappeared after about thirty applications of about five minutes' duration, the effleuve being applied to the sole of the bare foot; and "in one severe case of palmar psoriasis which had resisted various treatments for over two years, the effleuve for eleven sittings of five minutes sufficed to clear up the trouble." These are most remarkable results. The book is well printed, is elegantly "got up," and is illustrated by a number of blocks of instruments and apparatus similar to those found in the trade catalogues.

CURRENT LITERATURE.**ERYTHRODERMIE PITYRIASIQUE EN PLAQUES DISSEMINÉES.**

(*Journ. Cut. Dis. including Syph.*, April, 1903.)

CHARLES J. WHITE reports a third case from the Department of Skin Diseases at the Massachusetts General Hospital in the person of a Russian aged 44 years, long resident in the United States, who was the subject of an intercurrent affection of the foot, diagnosed as due to obliterating arteritis of the arterioles—the so-called "*hebräische krankheit*." The pityriasic eruption was of twelve years' duration and appeared in the winter months, and, in marked distinction to the erythrodermia of mycosis fungoides, was unaccompanied by subjective symptoms. The scalp was the seat of mild, non-congestive seborrhoea. The upper extremities, save the hands, displayed very numerous pinkish-red, irregularly circular *macules*, half an inch in diameter, especially distributed on the extensor aspect. On the front of the trunk below the nipples similar smaller macules were sparsely scattered, but lower down reached the diameter of an inch. On the back below the scapulæ were large, irregularly shaped, sparse lesions, becoming more abundant on the flanks. On the buttocks and thighs they were numerous and

* *High-frequency Currents in the Treatment of Some Diseases*, by Chisholm Williams. Rebman, Limited, London, 1903. Price 10s. 6d.

confluent, but almost absent on the lower legs and quite so on the genitals. The lesions everywhere disappeared on pressure, were the seat of fine, dry, very slight scaling, and were not pruritic. Small enlarged glands were noted in the axillæ and the epitrochlear regions.

The author says the histological changes observed in a macule from the thigh were nearly identical with those observed in Prof. J. C. White's case, viz.:

1. Open network formation of the stratum corneum composed of non-nucleated horny cells.

2. Absence of stratum lucidum.

3. Great atrophy or even total absence of the stratum granulosum.

4. In places compression of the retë cells and reduction of the layers comprising the stratum spinosum; absence of the palisade layer; and finally, greatest divergence from the normal directly over the parts of the corium mostly affected.

5. Œdematous condition of the corium.

6. Reduction in the amount of elastin.

The chief divergence was the absence of vessels and their accompanying perivascular infiltration in C. J. White's case, but this dissimilarity disappeared as the most seriously damaged areas were left for the periphery.

T. C. F.

SECONDARY ERUPTIONS IN SMALLPOX. JAY F. SCHAMBERG. (*Journ. Cut. Dis. including Syph.*, May, 1903).

DR. J. F. SCHAMBERG contributes a paper on "Secondary Eruptions in Smallpox," as distinguished from the prodromal rashes which are probably due to the variolous poison. The author has found the variolous lesions to be sterile until a late stage of the eruption, an observation which suggests that the *causæ causans* of smallpox is itself pyogenic. After the eighth or ninth day of the eruption a secondary infection appears to take place, and the streptococci chiefly, but also staphylococci and pseudo-diphtheria bacillus, are found plentifully. At this time a reddish vesicular ring, containing a turbid puriform secretion, forms around the partially desiccated crusts. These flat bullous patches spread peripherally as the concurrent central crusting proceeds, lifting up the epidermis as extension takes place until an area the size of a silver half-dollar is covered. Nearly all patients with unmodified smallpox present this extensive secondary eruption on the trunk and extremities. Symptoms of blood poisoning of more or less gravity may be present, and when death occurs in smallpox, which is usually from the ninth to the eleventh day, streptococci may in the vast majority of cases be recovered from the heart and other internal organs.

A second aspect of secondary pustulo-bleb formation is the one to which Hebra applied the term *Impetigo variolosa*. In this form, sparsely distributed, flat, or occasionally fuller blebs may spring up upon previously healthy interpustular areas of skin, most frequently about the hands and feet, and reach the size of a bean to a walnut. The roof is flaccid, thin, and wrinkled.

The secondary presence of these organisms is also in relation with the extreme frequency of boils and subcutaneous abscesses in smallpox.

The practice adopted at the Municipal Hospital at Philadelphia of giving anti-septic baths during the late suppurative stage of the disease would appear to be of great importance. The patient is immersed for fifteen to twenty minutes in a bath consisting of a 1 in 10,000 to 1 in 20,000 solution of corrosive sublimate, or

in 1 in 500 solution of creolin. After the bath the patient is dusted with weak antiseptic powders.

In a certain percentage of cases, between the sixth and twentieth days, and most commonly on the thirteenth or fourteenth, a scarlatiniform rash, not infrequently accompanied by a considerable febrile reaction, may develop on the trunk, extremities, and at times on the face, lasting two or three days, and, if well marked, prone to be followed by desquamation, sometimes profuse. The desquamation may on occasion be inordinate and prolonged. The skin immediately around the drying pocks is often exempted from this rash. On other occasions the rash may be somewhat morbilliform, and again, in rare cases, hæmorrhagic, especially on the lower extremities. The author relates a fatal case of secondary hæmorrhagic macular erythema. He quotes several authors who have discussed these eruptions.

[The reporter has recorded two cases of scarlatiniform rash complicating *Impetigo contagiosa*. It is also of interest to compare the behaviour of the *Varicella* eruption, and to read the description of *Pemphigoid Varicella* (G. Carpenter), *Bullous Varicella* (Pye-Smith), and *Varicellous Staphylococcia* (Bolognini).]

T. C. F.

CASES OF BULLOUS DERMATITIS FOLLOWING VACCINATION.

J. S. HOWE. (*Journ. of Cut. Dis. including Syph.*, June, 1903.)

DR. JAMES S. HOWE, of Boston, Mass., publishes a paper read before the American Dermatological Association on a remarkable series of ten cases of a pemphigus type received for treatment into the Boston City Hospital in January, 1903, whilst the vaccination of the population was in fullest operation. The author gives the following summary:—"All were cases of bullous dermatitis, all but one occurring in patients who had been recently vaccinated. The average duration of the disease in these ten cases was six weeks from the time the first skin lesions appeared until death or recovery took place. The longest duration of the disease in any one case was sixteen weeks, followed by recovery, and the shortest was one week, followed by death. The skin lesions began to appear in these cases in an average of five weeks after vaccination, sixteen weeks having elapsed in one case, the longest, and three weeks in one case, the shortest time between the time of vaccination and the first cutaneous disturbance. In the ten cases which followed vaccination there were six deaths, a most extraordinary mortality. In all the cases the parts most often affected were the back of the neck, the region between the shoulders, the axillæ, the buttocks, and the inner aspect of the thighs, and in these places there was a noticeable grouping of bullæ." The odour was intensely disagreeable, but subjective symptoms, apart from the extensive excoriated areas, were practically absent. The lesions in the mouth and pharynx made deglutition painful and often impossible, while corresponding lesions in the trachea produced an aggravating cough. Constitutional disturbance was very marked, the evening temperature averaging 101°.

Animal lymph seems to have been used in all the cases, and it is said to have come from a trustworthy source, and the vaccination process passed over without any local ill-effects.

Dr. Howe is not prepared to state the cause of the disease. Was it due to an infection? If so, was it due to the vaccine toxin acting on specially predisposed

subject? If a complicating infection was it introduced with the vaccine or subsequently into the wounds?

These cases contrast with the series published by Bowen (*Journ. Cut. and Gen.-Urin. Dis.*, September, 1901) in that the latter occurred in children, none of them were fatal, the trunk was spared as a rule, there was an apparent incubation period of only two and one half weeks, and the constitutional disturbance was trivial. Bowen (*Journ. Cut. Dis.*, June, 1903, p. 285) adds to his earlier list two further cases in children of much the same type as he formerly described.

We may remind our readers of the recent publication by Drs. Sequeira and Galloway of "Cases of Bullous Dermatitis following Vaccination," and of the cases recorded by Dr. Allen in the *Journal of Cutaneous and Genito-Urinary Diseases* for 1892 and 1893.

T. C. F.

THE PINSEN LIGHT TREATMENT OF LUPUS. Dr. W. KENNETH WILLS. (*Bristol Med.-Chir. Journ.*, June, 1903.)

THE author describes and figures a new lamp which he has constructed. He says the essentials in a lamp are: its light must be (1) intense, (2) rich in chemical rays, (3) cool, and (4) it must penetrate the tissues. It is possible, if not, indeed, probable, that the shorter the wave length the more useful the rays are; the longer they are, to a certain point, the deeper they penetrate. The rays in between the two extremes would therefore seem to be the most advantageous as possessing both these characteristics to a certain extent, and these include the extreme violet and blue. The light proceeding from an arc lamp with iron electrodes contrasts with that from carbons in being a bright violet in colour, and richer by far in violet and ultra-violet rays. In the "Dermo" and the Leslie Miller lamp used at St. Bartholomew's Hospital, the good results are not by any means proportional to the relative richness in chemical rays, and the reason, Dr. Wills says, must be sought in the want of penetration. Dr. Wills describes a new lamp combining the advantages of both the carbon and iron electrodes, an idea independently utilised in the Sanitas Company's "Triplet" lamp. In the Wills lamp, however, the iron is introduced as a thin wire running through the core of the carbons, and so yields its vapour in the burning of the carbons. Thus a light is produced very rich in the ultra-violet rays, and also in the rays of more penetrating power. The light is properly cooled, and the apparatus is portable. When used with a set-up transformer and a condenser, the alternating electric main supply can be utilised, and a very small amount of current is used, about $\frac{1}{2}$ amp.

T. C. F.

HEREDITARY EARLY SYPHILIS WITHOUT EXANTHEM. CARL HOCHSINGER. (*Archiv f. Dermat. u. Syph.*, May, 1903, lxx, p. 163.)

ALTHOUGH the diagnosis of acquired syphilis is largely dependent on the appearance of some form of eruption, this is not the case with congenital syphilis, and the latter variety can generally be definitely detected in the children before the slightest sign of changes in the skin becomes noticeable. The present contribution gives a detailed account of the early signs of congenital syphilis. A diffuse inflammatory alteration of the nasal mucous membrane is one of the most important of these. Swelling of the liver and of the spleen, and

an osteochondritic pseudo-paralysis of the upper extremities were also noted in a number of cases before any eruption came out. A group of fourteen hereditary syphilitic children is cited, in which there was no cutaneous manifestation of the disease at birth or afterwards, but which in their first year presented visceral and osseous changes. The nose was affected with a more or less profuse rhinitis in all the cases; in eight of them there was osteochondritis with pseudo-paralysis of one or both upper extremities; in one case there was phalangitis and disease of the ankle bones, and in another the bones of the skull were affected; and in six cases swelling of the liver was the only syphilitic manifestation. The spleen was enlarged and easily palpable in six cases.

J. M. H. M.

ON THE ACTION OF THE BECQUEREL RAYS ON THE SKIN.

HENRI HALKIN. (*Archiv f. Dermat. u. Syph.*, May, 1903, lxx, p. 201.)

IN the year 1896 M. Becquerel, a French physicist, made the discovery that the salts of uranium, as well as the metal itself, were capable of giving off rays which were absent from ordinary light. From the ore of uranium, named "pitchblende," M. Curie separated two radio-active substances—namely, radium and polonium,—and Debierne isolated a third substance with similar capabilities, which he named actinium. The rays from these radio-active bodies have the same power of penetration as the Röntgen rays, and a similar action on a photographic plate and a fluorescent screen. The physiological action of the Becquerel rays was described in a short communication by Aschkinass and Caspari, in which the action of these rays was compared with that of the X-rays and of light rays. They concluded that the Becquerel rays, like the X-rays, exercised an inhibitory action on the growth of tissues. From radium they got two types of rays: rays which had a great power of penetration and were not absorbed to any extent, and rays which were poor in penetration but had a great capacity for being absorbed. They found that the rays which had a feeble power of penetrating had a powerful bactericidal action, while the more penetrating rays of the type of the X-rays had no bactericidal effect.

Walkhoff and Giesel were the first to study the action of the Becquerel rays on the skin, and to show the great similarity of it to that of the Röntgen rays. Curie subsequently subjected his arm to the action of the rays for ten hours. Soon after the exposure the part became red, and in fifty-two days an ulcer developed. From the handling of radium Becquerel and Curie both got a dermatitis of the fingers, in which there was redness and scaling accompanied by painful sensations, which lasted over two months.

The histological action of these rays was studied on the skin of a young pig. 0.13 grm. radium-barium-bromide was enclosed in a thin aluminium capsule. This was placed in contact with the skin on one side for two hours, and next day on the other side for one hour. After thirty-eight days the exposed pieces of skin on each side were excised and examined histologically. The first of the exposed patches presented after eight days a somewhat livid appearance; and in twenty-five days the centre of it had the greenish-yellow colour of an old contusion, and became scaly. Microscopically the whole of the skin was affected, but the most marked changes occurred in the blood-vessels, the walls of which were degenerated; the epithelium was also affected by the rays.

J. M. H. M.

**ON THE PATHOLOGICAL ANATOMY OF SYPHILONYCHIA ULCE-
ROSA UNGUIUM HEREDITARIA. J. HELLER. (*Archiv f. Dermat.*
u. Syph., May, 1903, lrv, p. 235. Two plates.)**

IN the monograph by Heller on the *Diseases of the Nail* there is no description of the nails in hereditary syphilis, and it is to remedy this omission that the author has contributed this paper. He was fortunate in having the opportunity of examining a child who died at the age of 4 weeks, suffering from hereditary syphilis, and in whom the nails were severely affected. Three nails of the right hand and four of the left, and several of the toe-nails were implicated. The nail-wall and nail-bed were deep red in colour, and the nail-plate had disappeared in several nails, and been replaced by a soft moving mass partly composed of hemorrhagic crust. An examination of a large number of sections microscopically showed an acute inflammatory condition of the nail-bed and a widening of the posterior nail-fold, with the consequent production of a thickened nail-plate and gryphotic changes in it. There was an inflammatory infiltration of cells around the nail-matrix, and the nail-formation was interfered with in consequence. The infiltration of cells was also focussed around the sweat-coils. The blood-vessels were markedly dilated, and there was a dense sheet of infiltration at the pulp of the finger.

J. M. H. M.

**ACRODERMATITIS CHRONICA ATROPHICANS. LEVEN. (*Archiv*
f. Dermat. u. Syph., May, 1903, lrv, p. 247.)**

IN 1902, in this Journal, Herxheimer and Hartmann contributed a paper on a peculiar dermatitis of the extremities associated with atrophy, to which they gave the name of *Acrodermatitis chronica nasi*. In this paper the writer reports an additional case. The patient was a well-nourished middle-aged woman. About eleven years before she was seen by the writer she noticed a red spot on the extensor aspect of the elbow, and a lesion like a chilblain on the right little finger, and several other such lesions over the metacarpo-phalangeal joints. These lesions were not accompanied by pain. New lesions kept coming out up to the time the patient came up for consultation. When she was examined the whole extensor aspect of the right elbow was affected. The skin was livid red in tinge, and in the centre it was atrophic and thin, and like "crinkled cigarette paper." The skin over the metacarpo-phalangeal joints was similarly affected. The temperature of the atrophic skin was normal. The older the lesions the more bluish and livid did they become, the fresh ones being rose-red in tinge, and the skin was neither tense nor wrinkled. The left hand and arm and the lower extremities were not implicated. The affection has an early inflammatory stage, followed by an atrophy which begins in the centre of the lesion. The subjective symptoms are slight or absent. There was a certain degree of paræsthesia. The condition is differentiated from idiopathic atrophy of the skin from the fact that the atrophy is preceded by an inflammatory stage, while in the so-called idiopathic type the existence of a previous inflammation is denied.

J. M. H. M.

**ON THE NÆVUS-QUESTION. ED. RIECKE. (*Archiv f. Dermat. u.*
Syph., April, 1903, lrv, p. 65. Two plates.)**

THIS contribution is based on the histological examination of about 100 nævi, and was carried out in the dermatological laboratory of Professor Riehl, in

Leipzig. These nævi were of all varieties, such as ordinary soft nævi (n. spili), verrucose nævi, hairy, pigmented, giant-nævi; and they were obtained from patients at various ages from birth to old age. The writer discusses the various views with regard to the origin of the nævus-cells in the light of his own observations. In connection with the hypothesis advanced by Demiéville, Pick, Jadassohn, Löwenbach, and others, that these cells are derived either from the endothelium or perithelium of the blood-vessels, the writer states that throughout his preparations he found no definite change in the blood-vessels, and no connection between them and the nævus-cells, except accidental compression of the vessels by the mass of new growth. Similarly, with regard to the hypothesis of von Recklinghausen, that the cells are derived from the endothelial lining of the lymphatic vessels, the writer's preparations gave negative results. The most important rival theories are those of the epithelial origin of nævi advocated by Unna and his school, and their origin from connective-tissue cells supported by Simon, Virchow, Respighi, and others. The author discusses this problem at considerable length, and with Riehl adds his testimony to the latter theory. From his observations he is led to the following conclusions :

1. Nævus-cells are developmentally connected with the connective-tissue cells of the embryonic corium.

2. These embryonic cells persist in a partially developed state, in which they are capable of producing far less connective tissue and elastic tissue than normally ; but they can at a later age of the patient give rise to rudimentary connective tissue.

3. Nævus-cells at first closely resemble embryonic connective-tissue cells ; alterations in that appearance are the result of secondary pigmentation.

4. The cells appear to be capable of multiplying ; their " descendants " are likewise functionally imperfect connective-tissue cells.

5. The arrangement of the nævus-cells corresponds to the spaces between the fibrous bundles. In the nævus-area the fibrous bundles deviate in their distribution from that of the normal cutis, and they are generally only imperfectly developed.

6. The nævus-cell mass in the papillary layer causes a thinning of the epidermis from stretching.

7. Appearances which suggest a connection between the nævus-cells and the epidermis are the result of the upward pressure of the cells on the epidermis. This pressure can be so great as to cause the disappearance of the connective tissue and elastic fibres between the nævus-cells and the epidermis.

8. The pigment plays only a negligible part in the development of nævi.

The paper is illustrated by three reproductions, one being of a drawing showing rows of nævus-cells running down into the corium, and the other two being of photo-micrographs of nævus-cells ; a very full bibliography is appended.

J. M. H. M.

EXPERIMENTAL STUDY ON THE PATHOGENESIS OF URTICARIA. TÖRÖK and HÁBI. (*Archiv f. Dermat. u. Syph.*, April, 1903, lxxv, p. 21.)

THE writers of this interesting experimental communication contribute an important addition to the literature on the vexed question of the origin of urticarial wheals. The chief point at issue in this polemic is to decide whether a

wheel is an angio-neurotic phenomenon or whether it is an inflammatory lesion resulting from the local action on the blood-vessels of some irritant. The chief advocates of the latter hypothesis are Philipsson, Török, and Vas. In an experimental study on the subject, published in 1900 in the same journal, Philipsson stated that he found that a number of substances, such as atropine, morphine, and peptone, produced urticaria in the human skin as well as in that of the dog; and that these substances had the same effect on the skin of the dog after division of the sympathetic nerves to the part or the removal of the sympathetic ganglion. He concluded from his experiments that urticaria resulted from the action of certain irritants either directly on the walls of the blood-vessels or by circulating in the blood.

The researches of Török and Hári, here described, go far to corroborate Philipsson's theory. Their experiments were carried out in dogs, and the method of procedure was similar to that adopted by Philipsson. A fine-pointed glass capillary tube was filled with the substance whose action on the skin it was desired to decide; the pointed tube was then made to pierce the skin as far as the cutis, but not to reach the subcutaneous tissue. After a few minutes the tube was withdrawn, scarcely any of the fluid having left the tube. This excluded the theory that the wheal was artificially produced by the entrance of a mass of fluid into the corium. A large number of fluids were experimented with in this fashion. A number of these invariably induced urticaria, while others had no such effect. Concentrated solutions of the substances were employed. The result of their experiments showed that substances in solution, with regard to their capacity for producing urticaria, could be divided into three groups, namely:— (1) Substances which were indifferent, and caused neither urticaria nor œdema, such as cold sterilised water, acetone, glycogen, leucin, tyrosin, glycerin, 50 per cent. alcohol, normal salt solution, etc.; (2) substances which produced slight elevation and œdema of the skin, such as hot water, 30 per cent. solution of potash, oxalic acid, formic acid, globulin, casein, etc.; and (3) substances which caused the formation of typical wheals, such as peptone, pepsin, trypsin, butyric acid, palmitic acid, stearic acid, hydrochloric acid, cadaverin, kresol, carbol, antipyrin, phenacetin, morphin, atropin, toxins from *S. pyogenes aureus* and *B. coli*, etc. In short, the urticaria-producing substances may be regarded as certain of the ptomaines, toxins, antitoxins, and drugs; and these act by directly irritating the blood-vessels of the corium, which thus shows that urticaria is not an angio-neurosis, but a simple irritation-phenomenon.

J. M. H. M.

THE TRANSMISSION OF SYPHILIS. MATZENAUEER. (*Wien. klin. Rundschau*, 1903, Nos. 8 and 9.)

MATZENAUEER discusses the question whether the syphilitic father can beget a syphilitic child when the mother remains healthy. If the mother becomes infected and develops signs of syphilis, the possibility of her being delivered of a syphilitic child is of course undoubted, and *à priori* this can occur in one of two ways. First, through the ovum. But such a method of transmission has never been demonstrated in syphilis or in any other infectious disease, and it is at least very improbable. Secondly, through the placenta. Its occurrence has been indubitably shown in infectious diseases such as typhoid, and also in syphilis, and this whether the mother was infected during pregnancy or before

conception. The disease of the placenta may be diffuse or localised; thus in the case of twins one may be infected and the other not. And of importance is the fact of a healthy child being sometimes born although both the preceding and subsequent offspring are syphilitic.

But if the father be syphilitic and the mother healthy, can the offspring be syphilitic? The author says it cannot, for the following reasons:—No infectious disease is known which can be transmitted by the semen; the semen of a syphilitic is not infectious. Many more syphilitic fathers are known than syphilitic children. Men who suffer from even recent syphilis have healthy children if the mother remains healthy. Women who are apparently healthy, but who had syphilitic children by their first husband, continue to bear syphilitic children even if their second husband is healthy. The reason why no symptoms can at times be discovered in the woman depends partly on insufficient or faulty examination, partly on the fact that in 30 to 40 per cent. of tertiary syphilitic cases no previous symptoms can be proved. Colles' law asserts with truth that the mother of a syphilitic child is immune to syphilis. But inasmuch as it is impossible to acquire lasting immunity without having contracted the disease (passive immunity), and the mother of a syphilitic child is always immune, it follows that every mother of a syphilitic child, even though apparently healthy, must be syphilitic, even if the syphilis be latent. The hypothesis of paternal transmission is therefore unnecessary. The consequences of such a belief are obvious. Among others it follows that the treatment of the father has nothing to do with the fate of subsequently born children. The theory must, however, encounter, and has already met with, a very considerable amount of opposition.

J. L. BUNCH.

ERYTHEMA SCARLATINIFORME DESQUAMATIVUM RECIDIVANS. KRAMSZTYK. (*Jahrbuch f. Kinderheilkunde*, No. 3, vol. lv.)

IN this rare disease there is an eruption which resembles that of scarlatina, but is not preceded by vomiting, nor accompanied by sore throat or strawberry tongue. Moreover the secondary desquamation occurs earlier than in scarlet fever, is more copious, and in the form of large psoriasis-like plaques, and makes its appearance before the disappearance or even fading of the primary eruption. Complications may occur in the form of suppurative otitis and nephritis. But the criterion which distinguishes it decisively from scarlatina is its frequent recurrence. Attacks may be induced in predisposed individuals by various means, such as the taking of mercury preparations, oysters, etc. The author's three cases did not admit of the tracing of any such connection between cause and effect; and he is inclined to deduce from the rigor, the initial stage of fever, the headache, the involvement of lymphatic glands, kidneys, and middle ear that the disease is not a local infection only of the skin, but rather a general infection allied to the infectious diseases—a pseudo-scarlatina recurrens. But whether such a view will meet with general acceptance is perhaps open to some doubt.

J. L. BUNCH.

HEREDITARY SYPHILIS. MRAČEK. (*Wien. klin. Rundschau*, p. 135, No. 8, 1903.)

THE patient was a boy of 14½ years, with keratitis, Hutchinson's teeth, deafness, and perforation of the hard palate. The mother had had three abortions, then

eight living children who were incapable of survival. Patient was the twelfth child. The mortality of the descendants amounted, therefore, to 84 per cent. The mother's statement was that she was always healthy; her husband was also said to have had no illness. But after she had been married for twenty years, two years after the last pregnancy, gummata developed on both tibiae. She showed no other signs of syphilis, and had it not been for the appearance of these gummata her latent disease would not have been suspected. She had, however, had latent syphilis for twenty years.

J. L. BUNCH.

**FURTHER CONTRIBUTION TO THE STUDY OF SYPHILIS
BACILLI.** M. JOSEPH and PIORKOWSKI. (*Deutsch. med. Wochenschr.*,
Nos. 50—52, 1902.)

MEN who are syphilitic, although at the time free from all signs of the disease, occasionally beget syphilitic children two or three years after infection. It is to be assumed, therefore, that the semen of syphilitics retains the syphilitic virus for a long time. Starting from this assumption, the authors made cultivation experiments of the semen of syphilitics of one to five years' standing on sterile but unboiled portions of placenta. After forty-eight hours at 37° C. there developed on this medium small colonies like dew-drops, hardly visible with the naked eye, which gradually assumed a greyish colour and then tended to become confluent. These colonies were composed of bacilli arranged in a definite palisade-like manner, from 4—8 μ long, 0.2—0.3 μ thick, and somewhat thickened at one extremity. The shape resembled that of diphtheria bacilli, and the size was approximately that of subtilis bacilli. Staining was best accomplished with dilute carbol-fuchsin or gentian violet. With Gram they gave a positive reaction. Inoculation of the greyish colonies from placenta medium on to agar or human serum gave a greyish-white wax-like growth which showed through on the back as slightly yellowish. The bacilli of this second generation showed an oscillating movement. A third generation contained many degenerative forms. Some of these bacilli contained metachromatic bodies within their extremities. Milk was coagulated by the bacilli; no gas-formation occurred, but a slight indol reaction was observed in bouillon. On potato a slight moist, shining, whitish growth developed.

The bacilli were cultivated from the semen of thirty-nine individuals whose syphilitic infection had taken place within the previous five years, and in three cases of recent syphilis the bacilli were found in the blood. Similar bacilli have also been found in the blood of syphilitics by Waelsh and by Winternitz. The semen of ten individuals who had not had syphilis showed no bacilli. Rund has further found the bacilli absent in other five normal individuals. In fifteen old cases of syphilis, where the disease had been cured or had given rise to no recent symptoms, the bacilli were absent. One patient, on the other hand, who had a return of symptoms eight years after infection, gave a positive reaction when his semen was cultivated on sterile placenta.

In addition to proving the presence of the bacilli in the blood of recent syphilitics, the authors have also been successful in demonstrating their presence in the semen of patients microscopically after staining with carbol-fuchsin. This same semen also gave typical growths of the bacilli on placenta medium. The bacilli have also been demonstrated microscopically in hard chancres, in syphilitic

papules, and in plaques from the mucous membrane of the mouth, tongue, and tonsils.

The attempt was made to inoculate a young pig with a pure culture of the bacilli, and as a result (?) an eruption was produced on its genitals some fifteen days afterwards. But the animal died of swine fever two days after the appearance of the eruption, and some doubt was felt whether the skin appearances were due to syphilis or swine fever.

The researches of the authors have been ingenious and painstaking, and it is to be hoped that they may, even if not as yet quite conclusive, be in the end successful.

J. L. BUNCH.

LEPROSY. G. FILARÉTOPOULO (Athens). (*Journ. des Mal. Cut. et Syph.*, January, 1903.)

THE author of this paper recently spent several months in the leper colonies of the island of Crete in order to study more closely the principal questions relating to this malady. As a result of his observations and of his previous experience he draws the following conclusions:

1. Leprosy is a microbic disease, pre-eminently hereditary, and very rarely contagious. In the offspring of leprous individuals one of two things takes place: either an immunity is produced, or there is a contamination direct or indirect. When direct it gives place to true leprous lesions of the tuberculated type; when indirect it gives rise to local dystrophic lesions or to para-hereditary leprosy. By direct contamination is meant the actual passage of the bacillus of Hansen; by indirect, the transmission of the toxins of the bacillus. As to the contagiousness of leprosy, clinical evidence is almost negative; it can only rarely take place in the presence of ulcerating lesions and under certain ill-understood conditions of bad hygiene, want of cleanliness, predisposition, etc.

2. Two quite distinct forms of leprosy should be recognised—

(a) General leprosy.

(b) Local leprosy.

(a) General leprosy is either of the tuberculated or anæsthetic type, and these two types are mutually transformable and frequently co-exist in the same individual. The immediate agent of their genesis is the bacillus of Hansen.

(b) Local or trophoneurotic leprosy is the result of the toxins of the bacillus of Hansen, which are hereditarily transmitted by a process analogous to that which produces hereditary syphilis. This form may be regarded as an abortive leprosy; it is never contagious; the subjects of it never develop general tuberculate leprosy. The seats of predilection of this local form are the upper and lower extremities, especially the hands; also the lower eyelid. It manifests itself sometimes by atrophy of the thenar and hypothenar eminences, sometimes by contractions of the fingers and hands, sometimes by necrosis of the phalanges ("trophoneurotic mutilant").

3. The best prophylactic is the interdiction of marriages in order to prevent the hereditary transmission of the disease, together with thorough isolation of those affected, notwithstanding the low degree of contagiousness of the disease. The abortive forms need not be isolated.

4. Leprosy is curable, in the earlier stages especially, in spite of statements to the contrary.

5. The best means of combating the disease are hygienic and dietetic principally, and the abandonment of a climate where leprosy is endemic.

Mercurial injections and oil of Chaulmoogra in large doses (up to three hundred drops a day) constitute the chief antileprosy medications.

H. G. ADAMSON.

"UN ERYTHÈME FLUXIONNAIRE ET PERSISTANT" AROUND THE MOUTH. AUDRY. (*Journ. des Mal. Cut. et Syph.*, February, 1903.)

THE patient was a woman aged 37 years, in robust health. For five years she had been subject to periodical swellings of the lips; within a few hours the lips became œdematous, violet, smooth, the upper lip touching the nose, the swelling again disappearing in the same short space of time. The swellings were preceded always by hyperæsthesia of the left cheek. At the first attack there was a small bulla on the upper lip, but no vesicles or bullæ in subsequent attacks. In the intervals of the attacks there remains only a localised fixed redness with well-defined margins, without any subjective symptoms whatever. The patient had a congenital hypertrophy of the tongue.

Audry draws attention to the strikingly vaso-motor character of the phenomena, to the preceding localised hyperæsthesia, and to the peri-oral localisation of the œdema, and compares the case to those published by Hallopeau under the name of "Érythème perstans ou urticaire fixe."

H. G. ADAMSON.

THE PURPURAS. LOUIS TÖRÖK (Budapest). (*Journ. des Mal. Cut. et Syph.*, April, 1903.)

TÖRÖK protests against the multiplication of names as denoting different types of Purpuras. He maintains that all the true Purpuras are of similar origin, viz. that of some infective or toxic agent in the blood-stream; that their clinical differences are only differences in degree of severity; that there is no pathological lesion which is characteristic; and that at present the only scientific way of classifying them is according to their pathological cause.

He discusses all these points in full. The following is a summary of his conclusions:

1. Among the group of true Purpuras (which includes Scorbutus, Hæmophilia, Purpura simplex, Purpura rheumatica, Purpura hæmorrhagica (Werlhof), Purpura fulminans (Henoch), and Purpura urticans), it is possible, in the present state of our knowledge, to recognise as distinct diseases two types only, viz. Scorbutus and Hæmophilia; all the other forms of pure Purpuras must be thrown into one group—"Purpura hæmorrhagica." The clinical differences of the cases in this group are merely differences of degree, and no one symptom is characteristic of or peculiar to any. Again, the pathological histology of cutaneous hæmorrhages does not offer characteristic features for particular forms of Purpura. Some observers have found no pathological alterations at all; others have found certain changes, but these were different in similar forms of Purpura, identical in different forms. It is certain that many of these changes described are accidental, such as hyaline, amyloid, or fatty degeneration of the vessel walls. Endarteritis and thrombosis, when present, may play a part in the pathogenesis of hæmorrhages, since they augment the pressure of the blood; but they cannot alone

produce hæmorrhages in the skin, and they are often found without hæmorrhages. The clinical features and pathological histology of Purpuras (except Scorbutus and Hæmophilia) do not offer, then, any basis for their classification.

2. A study of the pathogenesis of Purpuras, however, shows new bonds of union. In the whole of this group cutaneous hæmorrhages depend upon causes acting directly upon the vascular walls and reaching their point of action by way of the blood-stream. These agents are of an infective, or of a toxic or autotoxic order. They are multiple, and different agents may produce the same clinical and anatomo-pathological picture. Apart from those analogous forms which are related to well-established diseases—as anthrax, smallpox, typhus, measles, etc.,—the Purpuras under consideration have been shown to depend upon various different infective agents; the Bacillus of Petrone, the Bacillus of Letzeinch, the Bacillus pyocyaneus, the Bacillus coli, Staphylococci, and Streptococci have been found by various observers in cases of Purpura. Scorbutus may be caused by a variety of infective agents, which come into play in the midst of certain predisposing conditions. The “nervous” origin of cutaneous hæmorrhages is in no way demonstrated.

3. It follows, therefore, that the chief task in the observation of Purpuras, either from a scientific point of view or for the purpose of accurate diagnosis, is the search for the pathogenic cause.

H. G. ADAMSON.

IS THERE A BOTRYOMYCOMA? F. J. BOX and J. ABADIE. (*La Presse Médicale*, June 6th, 1903.)

IN 1897 Poncet and Dor described as a special affection in man little frambœsiform pedunculated tumours on the fingers of the hand, having the structure of a sudoriparous adeno-fibroma and consisting of mulberry-like masses analogous to the botryomyces, or mushroom-like growths following castration (*champignon de castration*) of the horse. These authors thus constituted a new variety of neoplasm, well-defined in its clinical characters, its pathological histology, and its pathogeny, to which they gave the name of botryomycoma. Based on this and subsequent work, and aided by four new observations, the object of the present paper is to inquire if the tumours belong to a well-defined morbid type—if, in other words, a botryomycosis of man really exists. The clinical type corresponding to the little papillomatous tumours on the fingers of the hand, which surgeons have always considered to be benign inflammatory neoplasms, has been known for a long time. But if all the authors agree as to the clinical type, histological examination has given such different results that it may be asked if neoplasms of such variable nature correspond to the same clinical type, or if the differences of structure ought not to be attributed to errors of interpretation.

The search for the pathological agent has given rise to no less controversy, and has resulted, even if the perfect sterility of the tumour has not been proved, in replacing the specific agent of Poncet and Dor by the common *Staphylococcus aureus*.

Poncet and Dor's conception of the growth as a sweat-adenoma has been contradicted by numerous observers, especially by Savarind and Degwy, who think they mistook the newly formed vessels for sweat-glands. Bodin described the structure of the tumours as consisting of young tissue extremely rich in

vessels, especially in the central parts, where the appearance suggested that of a capillary angioma.

The authors' observations of their four cases, typical from a clinical point of view, also lead them to reject the conception of a sudoriparous adeno-fibroma. They find that the tumours consist of a new formation of embryonic connective tissue extremely rich in blood-vessels, which, voluminous and dilated in the deeper parts, become very abundant and form a close network of capillary anastomoses according to the degree in which they approach the surface. The dilated lumen of these vessels is lined by endothelial cells with large nuclei, and proliferated for several rows. The perivascular connective tissue is thickened, and consists of proliferated cells which form a thick fibro-cellular sheath. Towards the pedicle the vessels are situated in a dense fibro-lamellar tissue, through which they run in a zone of degenerated mucoid tissue. In the tumour itself the connective tissue becomes more and more loose, or even undergoes a total mucoid degeneration, so that the capillary anastomoses form a veritable trellis-work. Towards the surface of the neoplasm the vessels are surrounded by small, round, oval, or star-shaped cells, and this embryonic infiltration is disposed in nodular masses. At the periphery corresponding to the macroscopic ulceration there is a slight stratum of necrosis containing numerous leucocytes, and in which the degenerated vascular walls end by breaking up and disappearing. This connective tissue new growth is enclosed in a proliferation of the Malpighian layer, which forms papillomatous outgrowths round the pedicle and base.

In three of the cases no trace of sweat-glands existed; in the fourth they were present, but only at the edge of the tumour.

The name which seems to be most suitable for the neoplasm is that of fibro-papilloma, or more precisely muco-vascular fibro-papilloma.

Having decided upon the histological nature of the tumours, the authors proceed to discuss the reasons for attributing to them a botryomycetic origin. In the case in which cocci were found in the tissue of the tumour, their appearance did not differ from that of staphylococcus; their cultures could not be differentiated with precision from *Staphylococcus aureus*, and inoculations gave uncertain results. In most cases the cocci, isolated or in masses, were only situated in the necrotic detritus of the superficial ulceration, and not in the living tissues of the tumour. In several tumours from the horse which were examined by one of the writers, the histological structure was identical with that of the human neoplasms, *i. e.* fibro-papillomata, and, with the exception of some cocci on the necrosed surface, the bacteriological findings were negative. There exist in man, as well as in the horse, tumours which have the same fibro-papillomatous structure, some sterile, others showing cocci, the botryomycetic nature of which cannot be affirmed.

As regards the animal tumours, there is one point of great importance, *viz.* the production of "nodules of generalisation" of the same nature in the lungs or other organs. It is, however, possible to conceive that these are due to the staphylococcus, which in animals is able to cause not only the formation of pus but true granulomata. According to this hypothesis it is necessary to admit that the staphylococcus, from being a secondary agent of infection of the primary papilloma, becomes the causal agent of the pulmonary nodules. The authors come to the conclusion that they have not sufficient reason to admit the existence of a botryomycosis even if they have not been able to systematically disprove it.

S. E. DORE.

COLLOIDAL MERCURY IN SYPHILIS. SCHOLEN. (*Deutsche Praxis*, December 10th, 1902.)

THE author reports on the use of a colloid form of mercury. This is obtained with difficulty, and consists of a black metallic powder, soluble in ether and alcohol. This "solution" microscopically contains fine particles of colloid mercury.

The preparation is used as an ointment to replace the ordinary mercurial ointment, and contains 10 per cent. of mercury instead of 33 per cent. An inunction of five minutes is sufficient with 2 grammes of the ointment. The colloid mercury is slower in action than injections of perchloride. It is absorbed more quickly than blue ointment, and rarely causes stomatitis. Formula :

Colloid mercury	.	.	.	.	10	grammes.
Distilled water	.	.	.	.	10	"
Lard	.	.	.	.	80	"
Chalk	.	.	.	.	20	"
Sulphuric ether	.	.	.	.	1.5	"
Benzoic ether	.	.	.	.	3.5	"

It is also useful in bubo, epididymitis, and gonorrhœal arthritis.

Colloid mercury may also be given in pill form: 0.3 to 1 gramme to make thirty pills. One or two pills daily.

C. F. MARSHALL.

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THE BRITISH JOURNAL OF DERMATOLOGY.

OCTOBER, 1903.

RECURRING ECZEMA OF EXPOSED PARTS; HEAT ECZEMA, COLD ECZEMA.

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UNDER various names—*e. g.* Eczema erythematosum (Crocker), erysipelas-eczema (Hutchinson), and Eczéma érysipélatoïde récidivant des arthritiques (Brocq)—a type of eczema has been described that seems to have a claim to separate consideration.

A general description of these cases is given by Dr. Crocker (*Dis. of the Skin*, 3rd edit., p. 152) and by M. Brocq (*Mal. de la Peau*, 1890, p. 154). In the *Archives of Surgery*, vol. i, p. 127, Mr. Hutchinson quotes a number of most interesting cases, and gives a very full description of the same.

Sometimes without any obvious cause, but more frequently as a consequence of some known traumatism—such as exposure to cold winds, sun-rays, great heat, and certain chemical substances,—the face, and frequently the hands and forearms, are suddenly involved in an acute œdema with more or less superficial catarrhal dermatitis according to the nature of the exciting cause. The œdematous swelling may subside as quickly as it came, only to reappear on the slightest provocation. It is apt to recur more particularly in the spring and autumn, when the conditions favouring its development are in active operation.

The oedema may make its appearance in subjects who either show or have shown chronic eczema. It may, on the other hand, pass on into a practically incurable form of eczema.

The phenomena may be entirely confined to the exposed parts—face, neck, forearms, and hands. In some cases, however, they are accompanied by eruptions on the covered parts which, in some instances at least, are easily recognised, and appear to be directly dependent on the original exciting cause.

It goes without saying that cases of such a striking nature forcibly attract the attention, and this more especially so since the sufferers are much inconvenienced, and are often confined to the house for many days at a time.

For this very reason it is quite possible that they have received undue notice, and that they are merely exaggerated examples of more common and less noticeable affections.

A consideration of the cases goes far to show what an important part traumatism plays in their production, and particularly the physical conditions, such as cold winds and the rays of the sun. It would appear, too, that heat, independently of the direct exposure to sunlight, can act as an exciting agent.

During the past few years an enormous amount of labour has been devoted to the eczema question, and it must be admitted that it has not done much to clear up the subject. It is just as hard now to say what eczema is as it was before, and just as difficult to treat it. Still, some important points have been cleared up. Naturally a great part of the work has been devoted to a consideration of the parasitic origin of eczema; and in this connection the studies published by Kreibich and by Veillon are of especial importance. They showed that the primitive *clear* vesicle of eczema was amicrobic. I have had frequent opportunities to test the accuracy of their observations, and can fully confirm them. The method I adopted was to sterilise the surface with ether and alcohol, and then to lift off the cap of the vesicle with fine forceps and to place it on an agar slope in the warm. After two days the small pellicle of epithelium was broken up by means of a platinum needle. Part was spread over the surface, and the other part was used to make a film preparation that was stained in the ordinary manner. I found no organism of any sort. Later on I discovered that it was

possible to obtain a sterile surface by covering the part with zinc gelatine that was peeled off just before the vesicle was removed. I examined a considerable number of cases with negative results. Whenever the serous collection was straw-coloured or turbid, I invariably found staphylococci, and generally the *Staphylococcus aureus*.

For my part, and following M. Sabouraud, I regard these fluid collections as pustules, and I recognise that much of the present confusion of terms and of ideas depends on the varying interpretation of these elementary lesions. A case shown by one person as acute vesicular eczema is regarded by another as a pustular dermatitis, and there is no court to decide which is right. Obviously, however, the conception of the part played by micro-organisms in the production of eczema must be much influenced by the views held on this particular point.

Whatever view is taken as to the nature and meaning of these yellow serous collections, which almost invariably contain organisms, it is tolerably certain that the clear eczema vesicle is amicrobic, and some of the finest instances can be derived from the class of cases now under consideration.

In the summer of 1901, when the heat was very intense, I saw a man who was suffering from an acute eczema of the hands and forearms. The affected surfaces were swollen enormously, and this was specially marked on the extensor or exposed aspects, which were thickly covered with clear vesicles. The palms of the hands were also affected, and studded all over with the sago-grain vesicles that Mr. Hutchinson describes in some of his cases. Several attempts were made to obtain cultivations from the vesicles on the back of the hands, and also from those on the palms. In each instance the result was negative. The case was almost certainly one of acute dermatitis produced by sun rays, and as such would be excluded from the eczema class. I don't know the subsequent history of this man, but if it corresponded to that of other cases that I have seen he would be attacked again and again by the same disturbance, and the state produced would be absolutely indistinguishable from true eczema. Hebra taught that a great number of agents, acting externally, could produce eczema, amongst which he mentions chemical irritants and temperature. In this age of bacteriology much that Hebra taught has been forgotten or

denied, and the departure from his teaching has been aided by the continued attempt to separate the occupation dermatoses (grocers' itch, masons' itch, etc.) from eczema. Theoretically the distinction may be good, but practically these very cases form some of the most troublesome types of eczema that the dermatologist is called upon to treat. In order not to unduly extend the limits of this communication, I should like to consider the effects of cold winds and of heat and sun rays on the skin. If it could be established that these agents, acting alone, could produce true eczema, then it would be reasonable to suppose that other known irritants, when made to act *in a particular fashion*, could do the same. Croton oil, for instance, when applied, does not produce an eczema, but an acute dermatitis, that heals as soon as it is permitted to do so. But if croton oil be applied from time to time with the special object of producing an eczema, there can be little doubt but that the attempt would be in time successful. The chronicity of the case—and for eczema no explanation is sufficient that does not explain this point—may depend on two factors only :

1. The constant or repeated action of some irritating agent.
2. The damage done to the skin as the effect of such action.

The deleterious effect of atmospheric changes is only too obvious to all who study skin affections. It requires no special diathetic theory to explain why conditions hitherto endured without hurt become extremely harmful. Any departure from the normal physiological condition of equipoise may determine such action and permit the temporary establishment of a pathological state, *e. g.* an occupation dermatosis, a dermatitis due to sun rays, etc. The conversion of the temporary into a permanent condition must be sought for in the repeated exposure to the same irritant, in the skin changes induced by it, and in the liability of such damaged surfaces to be affected by new irritants, of which micro-organisms may be mentioned as the chief.

It would be foolish to assert that diathesis played no part in the production of eczema, when one sees daily cases in which the constitutional state actually induces the traumatisms—*e. g.* scratching and rubbing—that in turn produce the disease.

My object is to put forward reasons for believing that a very large group of eczema cases depend for their existence entirely on

simple traumatism, *i. e.* non-microbic, and that the constitutional state need play little or no part in the production.

Clinically, one encounters three important groups in the enormous mass of cases that have to be called eczema :

GROUP 1.—Cases in which the constitutional state dominates the picture, and the eczema is largely dependent on it.

GROUP 2.—Cases in which the skin is unable to endure the ordinary traumatisms to which it is subjected.

GROUP 3.—Cases in which the disease behaves as a parasitic affection from the commencement.

It is with Group 2 that I wish to deal, and, of that group, with the cases attributed to cold and heat.

The action of cold.—Whenever cold weather sets in, more particularly in the case of cold wind, a great part of the community suffer from chapped hands and faces. In individual cases it is ascribed to imperfect drying of the surfaces after washing, to the action of the fire, to friction, etc.; but the majority of people are in no doubt as to the proper cause, without which it would not be produced. Owing to the action of cold, the face and hands become covered with fine cracks and a slight branny desquamation. On parts where movements are free, such as the lips, the backs of the wrists, and about the finger-joints, the cracks often develop into deep and painful fissures, which heal very slowly so long as the cold weather continues, and are apt to become infected by pus organisms. The palms of the hands and the fingers become dry and hard and much fissured.

If this state be considered for a moment it will be obvious that there is something more than this fine cracking of the surface epithelium. There is, in fact, a slight œdema of the exposed surfaces. In many cases it is so slight as to pass almost unnoticed; but a great number show it clearly, and in some it is very pronounced. At the same time it will be noted that the skin of the covered parts is inclined to be dry and rough. There is an exaggeration of the state known as *Cutis anserina*, and the skin often itches dreadfully, more especially when the individual comes into a warm room or in bed. This leads to scratching and to the development of irritable papular eruptions (papular eczema) on various parts of the body. Thus, as the effect of cold, there are—

1. Œdema of exposed parts.

2. Cracking of the surface skin, fissures on the lips and fingers, and around the anus.

3. A pruriginous condition of the skin of the body and extremities, with a tendency to dry, itching, papular eruptions.

4. Frequent development of impetiginous sores.

The changes encountered naturally vary considerably in accordance with the general state of the person affected. In those who are full-blooded, with the vessels distended, the œdema is apt to be very conspicuous, the surfaces become bright red owing to the dilatation of the vessels, and the cracks, instead of remaining dry, give issue to a serous discharge that coagulates on the surface. The cracks also become converted into superficial excoriations. Many of these cases give a history of pseudo-erysipelas. In those who are fat the papular eruptions are more pronounced.

In the numerous cases in whom a spare habit of body exists, with anæmic skin and absence of subcutaneous fat, *e. g.* xeroderma, the effects of cold are most marked. The hands become very dry and wasted; the cracks extend in every direction and become very deep. The palms are rough and dry, and much fissured. In fact, the state produced is that known as Eczema rimosum.

To my mind a consideration of the state known as "chapped hands and face" indicates that it is the groundwork on which a very large class of eczemas are built up, which might well be called *eczema a frigore*.

Such cases show the three features already noted—namely, œdema, cracking, fissuring, and excoriation of the surface and pruriginous eruptions. They tend to recur with the cold weather, and with each reappearance to be more resistant to treatment. When the initial damage is very severe the eruption may not recover, and may so pass at once into one of the most chronic forms of eczema.

I will give a few illustrative cases. The first is under the charge of my colleague, Dr. Marshall, whom I thank for permission to mention it.

A girl aged 16, domestic. Attacks commenced when she was three years old, and have reappeared every year, mainly in the spring and autumn. Eczema confined to the face and hands. The surfaces are œdematous, scaly, and cracked. There are many deep and ugly fissures on the lips and fingers. The affected surfaces are

slightly erythematous, but not really red. The scalp has never been affected.

W. S—, a male aged 30. Duration of present attack, five days. He has had similar attacks for fifteen years every spring and autumn. They come after exposure to cold winds. Six years ago he had an attack of erysipelas (?). There was no fever, and he did not feel ill, only his face was greatly swollen and red. When seen he showed a peculiar eczematous eruption on the face. The whole of the nose was affected, and the rash extended out on to the cheeks along the ridge formed by the muscles. On the left side it soon faded away into a merely reddened surface, but on the right side it covered the greater part of the superior maxillary region and the malar prominence. It extended upwards along the supra-orbital ridge to about the centre of the orbit, and backwards along the zygoma to the ear. The whole of this surface was deep red in colour, swollen, and traversed by superficial excoriations, owing to which the horny layer was peeling off in flakes. Each lobule of the ear was deep red, swollen, and excoriated. On the sides of the neck beneath the angle of the jaw and covering the mastoid region was an eruption of various-sized red papules, or clusters of papules, such as one sees in ordinary eczema. It was impossible to see this case without being reminded of Lupus erythematosus, there being a remarkable resemblance. At the end of a week the swelling had disappeared, the redness nearly gone, and only some scaliness remained, with some injection of the vessels. On the following week, owing to a return of cold weather, he had a relapse. He is now nearly well, but it is interesting to note that his nose is becoming chronically eczematous, and does not improve as the other parts have done. The scalp was not affected.

M. J. M—, female, aged 56. Disease commenced about 12 years ago, at the time of the menopause, by what she described as "flushes," which appear to have been swellings of the face. These were followed by the appearance on the neck and in the bend of one elbow of scaly red patches that have persisted ever since. Six weeks ago an attack of acute erysipelas (?) that followed a ride on the top of a 'bus, in the course of which she was severely chilled. She felt very ill, but there is no evidence to indicate that the "erysipelas" was accompanied by fever. The erysipelas developed

apparently into a general exfoliative dermatitis, in which the skin came off in large flakes from the trunk and extremities. When seen, the whole face, neck, and upper sternal region were swollen, deep purplish red, and scaling profusely. "There is vivid erythema in the bends of the elbows, with numerous and deep cracks, which prevent the full extension of the arm. The rest of body has evidently improved rapidly, since it shows little; merely isolated red papules and slight scaliness in places. Beyond a slight degree of scurf the scalp is not affected. She has a fine growth of hair, which has not fallen out. Considering the intensity of the inflammation on the face and neck, it is a little remarkable that the scalp has remained unaffected." This case illustrates the fact that after exposure to cold, although the exposed parts are most affected and take longest to recover, the covered parts may be affected as well.

W. B—, male, aged 36. Carman, much exposed to weather. He had pleurisy in January, 1902, and was laid up for three weeks. Not long after recommencing work, he was exposed for the greater part of a day to a storm of sleet, as a consequence of which he felt chilly. On his return home his face swelled. I saw him three weeks later. The lower half of the face from the eyes downwards was much swollen and bright red. The affected surface was traversed in every direction by cracks and narrow excoriations which exuded serum. The ears were affected in the same fashion; on the neck was a papulo-macular eruption due to a serous exudation round the follicles. The backs of the hands and fingers were swollen and much cracked, with some deep fissures. His forehead escaped because his hat came down as far as his eyebrows. I have had this man under my charge for more than a year. He presents a typical chronic eczema of the face, neck, and hands. Sometimes it gets nearly well, and then reappears as badly as ever. It is interesting to notice that the sun now does him harm as well as the cold. The forehead, which escaped at the first attack, has not been affected, and the scalp is perfectly healthy.

All generalisations concerning eczema are notoriously dangerous. Most prove false, and such as are true are generally old. Yet I see some reason for thinking that there is a form of eczema due to cold and to no other cause, and that such cases can be readily distinguished and possess features peculiar to themselves, of which the œdema,

the cracking of the surface, and the involvement of exposed parts are the chief, as well as the pruritus and regular recurrence. .

The idea seems to me to be of some value, since I find that, by applying these tests to old cases described in my note-books, I can easily recognise a great number whose nature and origin had, at the time the notes were taken, been difficult to explain.

I now see that a number of cases of eczema in babies of a very special type belong to this class. A perfectly healthy, fine-looking baby is brought showing a dry eczema of the face, neck, and backs of the wrists. Usually the scalp and forehead escape. The eruption commences on each temporal region, extends over the cheeks on to the chin, and perhaps on to the neck. It is usually symmetrical, vivid red in colour, and shows the cracked condition so characteristic of the type. The eruption on the wrists is similar in character. The cases come in the cold weather, and they relapse very readily.

This condition has generally been considered to be of reflex origin. It is almost always possible to find some cause for reflex disturbance in babies as in other persons; but the theory has never appealed to me, more particularly as some of the children are conspicuously healthy. The effect of exposure to cold may well be thought of in such cases.

A great number of cases of *Eczema rimosum* come under this heading, as also many of the numerous cases of eczema of the face and hands that come for treatment. I feel sure that an examination of the cases of winter prurigo will yield interesting results.

The tendency for cold to aggravate eczema has been known from time immemorial; but it is strenuously denied that these simple irritants can produce the disease. They are said to produce merely a simple transient catarrh, and when eczema arises as a consequence, appeal is made to some subtle thing—an eczema tendency, a diathesis, a something failing which eczema cannot exist.

It would be foolish to maintain that there are not some states that, more than others, predispose to eczema. The point is incapable of proof one way or other. Yet it is noteworthy that, after so many years of study, so little is known about these predisposing constitutional states. There is some excuse for thinking that they really play a small part in the genesis of the disease.

On the other hand, the part played by simple traumatic influences,

e.g. cold, sun heat, chemical and mechanical agents, etc., in originating and perpetuating eczema, is a matter of daily experience ; and a catarrh once produced by one agent can be kept up by the continued action of that particular agent, and, what is more important, by the action of others. To give a simple instance : A bricklayer has his skin constantly irritated by lime. One day the skin becomes inflamed, and he has to seek treatment. From this time on he cannot stand warm weather, and he finds that whenever he is exposed to intense sun-heat his skin becomes inflamed. It would be possible to multiply instances and ring the changes indefinitely from actual practice. There is, in fact, a catarrh originated by a simple traumatism, and maintained or reproduced by the same or other traumatic influences. It is not necessary to seek for a special constitutional state, or to invoke the aid of the nervous system ; and obviously micro-organisms play merely a secondary part in the process.

At some particular moment the damage is done, and the skin structures, hitherto able to endure the extreme reactions to which they are naturally exposed, now fail to react. It may well be, and generally is the case, that at this moment the patient's health had been impaired by some illness, by alcohol, etc. But often the patient's health is excellent, whereas the traumatism has been excessive. When once the damage has been done, a host of other influences come into action, amongst which micro-organisms play a very important part as well as heat and cold.

If it should be possible to take some particular agent—such, for instance, as cold,—and to show that it produces an eczema differing in certain important particulars from eczemas produced by other means, it might be possible to distinguish other types, and thus build up by degrees a new classification of cases that would be of real use in the treatment of the disease. To a certain extent this has already been done, since every careful observer tries to discover the cause or causes that have been at work to produce the case before him. Their very number increases his belief that the one real cause is hidden from him. To my mind the conception of the disease is rendered far clearer if this “one real cause” is put entirely out of view. A disease so multiform in its appearance can scarcely have a single cause ; it must be the product of many.

The action of heat and sun rays.—Whenever there is a sudden

change of temperature, and, specially after the first outburst of warm weather in the spring, the hospitals are flooded with patients suffering from eczema. It is unnecessary to state such a self-evident fact as that heat aggravates eczema; but this experience makes it reasonable to inquire if heat may not actually produce it, and, what is more, produce some type that can be clearly distinguished from others.

The inquiry is by no means simple. Not only are most eczemas aggravated by the sudden onset of hot weather, but there is the influence of the sweat function to be considered, and the different action of heat and of the rays of the sun. Then, too, just as the eczema due to cold is a reaction produced very largely by the return to the warmth, so the reaction brought about by heat depends largely on the degree and rapidity of the subsequent chilling.

In the first instance the reaction is produced at the time when the cutaneous vessels are reduced to their smallest dimensions, and the extra-vascular tissues are driest. For this reason the strain on the vessels is great, and may even lead to an effusion of blood, as in the case of chilblains and certain hæmorrhagic eruptions. Usually the subcutaneous œdema is the chief feature, and the surface skin is stretched and cracked by reason of it whilst in the worst possible condition to undergo such a process.

In the second instance the reaction is produced when all the surface vessels are widely distended, and the extra-vascular tissues loaded with serum. As a natural consequence, the changes produced by heat are certain to be more acute, and attended by a much greater degree of serous exudation on the surface, and of swelling of the epidermis.

It is, of course, desirable but extremely difficult to distinguish between the direct action of radiant heat and light on the one hand, and the indirect effects produced by the change of temperature on the other.

As might be expected, the various forms of radiant energy have an action on the skin in inverse ratio to their power of penetration. It is very difficult to say whether or not the ultra-violet rays have any appreciable damaging effect on the skin. If, as seems probable, most of the lamps now used for the light treatment of lupus do not allow such rays to pass, then many of the assumptions as to the effects they produce will have to be given up. By reason of their

increased power of penetration, it would seem probable that their effect would be produced not on the skin, but in the deeper parts, where their course tends to be intercepted. In fact, though we speak a great deal about the action of ultra-violet rays, very little is really known about them. Beyond a possible influence on pigment formation, it is hard to see what effect the photo-chemical properties of these rays can have on the skin. On the other hand, we do know that radiant heat can destroy the skin almost in an instant. In a less concentrated form it can blister it to any degree. And we know that light, when applied in a concentrated form for a longer period, acts in precisely the same fashion.

Hence it is fairly obvious that when an acute dermatitis follows exposure to sunlight, it *can* be originated by the combined action of the heat and light rays. On a very bright day, when the sun rays have nothing to intercept them, the light alone must be almost sufficient to blister the skin of an unaccustomed person, and the light and heat rays combined certainly can do so.

It seems to me that Dr. Bowles, in his paper, "The Influence of Solar Rays on the Skin" (*Brit. Journ. of Derm.*, 1893, p. 237), has omitted the most potent cause of sunburn, *i. e.* chilling after exposure to heat, and for this reason his conclusions must be regarded with suspicion. This is the more curious since this most interesting communication has many suggestive statements. He says:—"How grateful is the change from the hot and oppressive moraine to the refreshing coolness of the glacier!" He notes that Mr. and Mrs. L— were burnt on the Pigne d'Arolla, although they did not see the sun from start to finish. They were very cold. Professor Langley, in ascending Mount Whitney, found that the higher he went *the cooler it grew*, and the more the sun burnt the skin. Glass-workers, iron-workers, etc., may, it is true, be exposed to high temperatures (400°—500° F.) and not be burnt. But I question if any of the Alpine guides suffer from sunburn. It is a matter of habit, and it is the unaccustomed that suffer. The actual temperature does not count. The only question is, Can the person endure the subsequent reaction on passing from the hot to a cooler atmosphere?

It is by no means necessary to call in the aid of the ultra-violet rays to explain the phenomena. Nor is it necessary in these cases to appeal to streptococci, or any other micro-organisms. They may be

present ; in fact, any acute effusion of serum on the surface may favour their growth. But it is an outrage on common sense to believe that a dermatitis that follows immediately on a definite, and usually severe exposure, and the acuteness of which subsides rapidly as soon as the case is removed from the sunlight and treated with some simple cooling application, can be due to the action of micro-organisms.

It is not unreasonable to suppose that sunlight can damage severely the skin of an individual who is normal in every respect. But in most of the cases there is some predisposing factor that renders the subject more susceptible to injury, and that may be so much in evidence as to entirely obscure the real cause of the attack. The patient's skin may be unusually sensitive to sun rays, or his occupation unfits him to bear them. Some illness may previously lower his tone. It may well be that when the predisposing factors are well marked, a dermatitis, really due to sun rays, is ascribed to some other cause. And what happens as the result of exposure to sun rays almost certainly follows exposure to heat rays from a fire. The eczema so commonly met with on the shin-bones of stokers, and on the thighs and forearms of women who do much cooking, often has this as a cause.

Willan and Bateman made Eczema solare the first of their three species of eczema. It is evident that they regarded it as a distinct affection, and they ascribe it to irritation from the direct rays of the sun and from heated air. The name was changed by Tilbury Fox to E. simplex, and the class swept away by Hebra, who took it into his one and all-embracing disease, eczema.

Few or no persons believe now that eczema is a single disease. It represents the action of many traumatic influences, and since the reactions of the skin are necessarily limited in number owing to structure, inflammations due to many varied causes may closely resemble one another. But it is important to remember that, when they do so resemble one another, the irritants causing them almost certainly act in the same fashion. It seems possible in this way to secure a rational grouping of cases, which will be useful not only diagnostically, but for treatment as well.

It is easy to recognise Willan's E. solare from the description given, and the cases are so different from some other types of eczema as to deserve different names. In hot weather there are

plenty of cases, and they present a remarkable degree of uniformity as to their main features.

There is an acute flow of serum to the surface, mainly of the exposed parts, but also of the trunk, and particularly the axillary and genital regions. The serous flow may merely form a red and swollen surface, but more commonly it causes an abundant eruption of vesicles, whose contents at first are clear and later turbid.

Where there is any obstacle to the outrush of serum, such as is afforded by the thick horny layer of the hands and feet, large bullæ may form (cheiropompholyx).

It is especially characteristic that the vesicles often rapidly coalesce, causing a complete exfoliation of the horny layer and the formation of large, raw, weeping surfaces. This takes place more particularly on the hands, forearms, and face.

Bateman remarks on the resemblance some cases bear to scabies, and Hutchinson has repeated the observation.

The eruption subsides rapidly, but is very apt to recur with a return of hot weather.

The face may be enormously swollen, but the œdema is more on the surface and more inflammatory than that caused by cold winds. Any existing eruption is apt to be aggravated, and this applies with particular force to seborrhœa of the scalp. The whole scalp may be red and weeping, and the greater part of the hair fall out.

The two conditions may well be compared in the following table:

	Eczema due to cold.	Eczema due to heat.
Onset	Sudden and acute	Sudden and acute.
Course	Quick subsidence with frequent relapses. Recurrences common. In time becomes a chronic affection	Quick subsidence with frequent relapses. Recurrences common. In time becomes a chronic affection.
Distribution	Mainly confined to the exposed parts—face, neck, forearms, and hands. Pruritus of covered parts common. On the face special preference for nose, skin over malar bones and zygoma, lobules of ears	Mainly confined to exposed parts—face, neck, forearms, hands. Eruption also common on genitals, in the axillæ, and on parts covered by warm clothing, <i>e. g.</i> the vest area; or on parts specially exposed to heat, <i>e. g.</i> the thighs in cooks, the legs in stokers.

	Eczema due to cold.	Eczema due to heat.
Type	Erythematous-squamous, with cracking or fissuring of the surfaces. At times marked œdema of face—œdema sub-cutaneous. Secondary pus infections common	Vesicular. Rapid exfoliation of large portions of the horny layer, with formation of raw red weeping surfaces, showing little tendency to crust formation. At times marked cutaneous œdema of face. Furuncles common.
Special local features	Scalp rarely affected. Hands, dryness and deep fissures often the only sign. Erythema slight. Same on palms. On cheeks and nose may bear a close resemblance to Lupus erythematosus	Scalp commonly affected. An existing seborrhœa of the scalp may be greatly intensified. On the covered parts and between the fingers often closely simulates scabies (Bateman, Hutchinson). On palms and soles in extreme degree as cheiropompholyx.

Thus there are two perfectly distinct types of eczema, due to different causes, that resemble one another in certain particulars, and differ just as markedly in others. They can be easily recognised and distinguished the one from the other if seen at a fairly early stage of development. Later, when chronic changes have become conspicuous, and other traumatic influences, *e. g.* scratching, micro-organisms, etc., have introduced fresh features, the recognition is far from easy.

I believe these two forms are in no way dependent on micro-organisms for their production, and that they are directly due to cold and heat respectively. These agents can act injuriously without the intervention of any predisposing cause, but more commonly some predisposition has paved the way. Such may be an illness that lessens the power of resistance of the patient. More commonly it exists in the life of the individual who is, owing to his habits or occupation, unfitted to bear the strain. Thus a person who works all day in a hot room bears the cold badly; one who works in a dark room is affected by the sun. A very important predisposition lies in the gradual damage done to the skin by irritating occupations. To give some typical instances.:

A man is employed in chemical works, where the skin of his face and hands is constantly irritated by fumes. He develops an

eczematous dermatitis on these parts. This is treated and seems to disappear. He is then exposed to intense sun heat and develops an acute dermatitis, marked by swelling and redness of face and ears and a copious serous discharge. The hands and forearms become enormously swollen. Large portions of the horny layer exfoliate off from the forearms, leaving raw, red surfaces. Large bullæ form on the backs of the hands, between the fingers, and on the palms. This eruption tends to return again and again, always taking the same form. However long he might have continued his irritating occupation, he would never have developed an inflammation of this nature without the intervention of the heat.

The same applies to some cases in which acute eczema attacks bricklayers, plasterers, etc. Owing to the nature of their occupation these subjects are constantly exposed to a great number of traumatic influences, and the cases are very hard to disentangle. But they are specially exposed to the weather, and the sun plays a very important part in the causation of the eczema they are so prone to suffer from, and also in the type it is apt to assume.

There is nothing novel in the views I am putting forward. Their only merit is a respectable antiquity. In the days of Willan eczema was a simple subject that could be dismissed in a few pages. Now it seems to require huge books of from 300 to 500 pages, and the longer the book the more confused the picture becomes.

Eczema is either a very simple matter or else its true nature is entirely hidden from us. Taking into consideration its universal distribution, and the fact that in such a large number of cases the disease results from a definite and well-known form of traumatism, and only appears on the parts so affected, there is good reason for holding the former opinion.

No one who wishes to understand eczema would take as a model the cases in which the disease has existed for many years, and has by degrees spread over the greater surface of the body. Much can be learned from them, but they throw little light on the causation.

It is only by taking cases at an early stage that it is possible to form any idea of the processes by which a chronic and extensive eczema is evolved. Then with each case the following questions arise :—Is this case due to any particular traumatism? Does it correspond in features to other cases produced by the same irritant?

Can it be distinguished in any way from cases due to other irritants? Is the trauma in question adequate to start the disease, and adequate to maintain it when once started? Has any other form of traumatism intervened to change the type? Is there anything in the state of the patient to enable one to assume that the eruption in question might have appeared without the action of any external irritant?

If it can be established—and I think it can—that such agents as heat and cold are adequate to produce and maintain an eczema, and that the form produced depends on the agent that is acting, then it should also be possible to establish that other irritants, playing an important part in the production of eczema, could do the same, and that each form so produced could be distinguished from all the rest. The differential diagnosis would depend not so much on the actual lesions, but on their grouping, time of appearance, behaviour, etc.

The only merit I claim for this communication is that it is a slight effort to make a start in what I believe to be the right direction.

SOME REMARKS ON THE PATHOLOGICAL ACTION OF THE RÖNTGEN RAYS, WITH SPECIAL REFERENCE TO THE LITERATURE ON THE SUBJECT.

BY J. M. H. MACLEOD.

IN spite of all the careful work which has been done in connection with the Röntgen rays since their discovery in 1896, and the great literature which has now collected around the subject, there is still considerable uncertainty both with regard to the nature of these peculiar radiations and their precise action on the tissues. The time-honoured theories that the beneficial effect of the rays from a Crookes' tube is the result of a thermo-chemical action, or a vague electrical influence, or the generation of ozone, have now become obsolete and been superseded by the view that these radiations have a specific action on the tissues; but it is still a matter of conjecture whether the effect on the skin, especially where dermatitis or burning is produced, is not partly due to the electrical effluvium around the tube. Thomson's experiment, in which he was able to

cause a burn when a piece of aluminium foil was interposed between the skin and the tube—the aluminium being transparent to the X-rays but opaque to the discharges from the electrical field around the tube,—went far to prove that the X-rays alone were the potent factor. On the other hand, several workers on the subject still hold the converse view; and it has been suggested by Norman Walker and Gardiner that both the X-rays themselves and the electrical field produced by a high alternating current may be active, and that with soft tubes the X-rays may be the main agent, while with hard tubes it may be the electrical field that is most potent. The greater activity of a soft tube with a low vacuum in producing X-ray burns than a hard tube in which the vacuum is much more complete, seems also to call for further explanation than simply to say that in the case of the soft tube the rays which emanate have a longer wavelength and a weaker power of penetration than the rays from a hard tube, and consequently produce greater destructive changes on the tissues through which they pass, in much the same way as bullets of low velocity cause far greater destruction than the modern bullet of high velocity. It has been suggested that a greater number of X-rays are given off from a soft tube. This problem, which is one of the utmost importance to those who employ the rays therapeutically, we must leave meanwhile in the hands of the expert physicist.

What I am concerned with, however, in this contribution is not so much those physical problems, but the questions of the pathological action of the rays, the histological effects they produce on the tissues, and the consequent indications for their use. During the last few years a number of important investigations have been recorded bearing on the pathological action of the Röntgen rays. Histological examinations have been made of healthy skin in man and in various animals. After a varying number of exposures to the rays, ulcers and telangiectatic scars resulting from their action have been studied, and a number of skin lesions—such as *Lupus vulgaris*, rodent ulcer, and epithelioma—in process of treatment by the rays have been examined microscopically. Bactericidal experiments have not been wanting, and the action of the rays on cultures of the more common micro-organisms has been investigated and reported upon. There is a certain degree of unanimity in the majority of these results; and in view of the growing popularity of X-ray treatment and its liability

to abuse, it seems fitting to pause and consider what is actually known with respect to the action of the rays on the elements of the skin both in health and disease, and to critically survey the various investigations on the subject. One of the first and most natural hypotheses with respect to the beneficial action of the rays in the treatment of Lupus vulgaris and other skin affections due to micro-organisms was that they were bactericidal. It was believed that, like the actinic or chemical rays of the solar spectrum, they possessed the power of inhibiting the growth of micro-organisms both in the tissues and on cultures. This theory has now been definitely proved to be erroneous, so far as cultivations of micro-organisms on artificial media are concerned, by the researches of Freund, Zeit, Wolfenden, Forbes Ross, and others. Wolfenden and Forbes Ross found that instead of inhibiting the growth of tubercle bacilli the X-rays actually "stimulated them to excessive growth, and only affected them adversely by attenuation from overgrowth." Their experiments with cultures of the *B. prodigiosus* gave similar results. It does not necessarily follow that the rays may not be capable of indirectly interfering with the life of bacteria in living tissues. As Pusey observes in a recent paper, "the cleaning up of infected ulcers and the disappearance of sycosis and acne under the influence of the rays" seem to prove that pathogenic micro-organisms in the tissues may be destroyed by the rays. This bactericidal effect, the existence of which most observers will admit, is indirectly produced by the rays through the stimulation of a healthy reaction on the part of the tissues. Skinner suggested that it was due to such changes being produced in the tissues as to render them unfit for the further growth of micro-organisms. Freund and Pusey believe it to be the result of increased phagocytosis.

Until lately it was generally believed that the curative action of the chemical rays of the spectrum, as obtained from a Finsen lamp, on tuberculosis of the skin, was mainly dependent on the inflammatory reaction which resulted from exposure to these rays, and that the amount of benefit was actually proportionate to the degree of reaction. While admitting the bactericidal effect of the chemical rays, the resolution of the tubercular granuloma was considered to be indirectly produced. When the Röntgen rays began to be employed in similar cases an inflammatory reaction was also believed to be essential, and for this purpose long exposures were given and soft

cases were associated with the result that X-ray dermatitis, burns, and ulcers occurred comparatively frequently. It is now the common experience that cases can do well under exposure to the X-rays without any decided inflammatory reaction being set up; and unless in exceptional circumstances, such as the breaking down of the cartilage at the edge of a rodent ulcer, a reaction is generally avoided by stopping the exposure immediately the signs of it become evident, and by the employment of hard tubes. It is now generally admitted that the X-rays have a direct specific action on diseased tissues, causing their devitalisation and eventual destruction. There is a tendency also to claim an analogous specific action for the chemical rays of the spectrum, and it is taught by the Copenhagen school that the blue-violet rays have a direct action not only on micro-organisms, but also on the granulomatous tissue around them. The histological appearance of sections of Lupus vulgaris after exposure to a Finsen lamp gives evidence of the beneficial effect of the inflammatory reaction, and suggests that it would be quite sufficient to account for all the changes noticeable in the granuloma.

The microscopical appearances in tissue which has been X-rayed differ, however, from those after exposure to the Finsen lamp, and destructive changes in the diseased tissue are present which seem to be independent of an inflammatory reaction. The action of the X-rays is slower than that of the actinic rays, but appears to be cumulative in so far that after a time the toxic products of the cell, which have been destroyed by the direct action of the rays, become sufficient in quantity and virulence to be capable of setting up a reaction, which is peculiar in type since it occurs in a tissue already weakened in resistance by prolonged exposure to the rays, and is apt to lead to ulceration, necrosis, and sloughing, and to the formation of imperfect telangiectatic scars.

Kaposi used to teach that the X-rays acted primarily on the blood-vessels, causing an alteration in their muscular tone and paresis, and that the resorption of the granuloma of tuberculosis was the result of a fatty or molecular change in the cells. It next became fashionable to ascribe their action to the influence of the rays on the nervous system. Destot believed it to be a tropho-neurotic phenomenon. Oudin, Barthélemy, and Darier, in a series of experiments with the X-rays on guinea-pigs, found that when a defluvium of the hairs took

place, in the hairs which fell out the bulb of the hair was complete, but on the sections of the irradiated skin the hair-follicles were atrophied, while the epidermis was thickened, and there was an increase of pigment on it; these appearances they considered to be the result of a nervous influence leading to the obliteration of the blood-vessels of the corium and their branches to the hair-papillæ.

Various other hypotheses were put forward. Bordier suggested that the rays acted by interfering with the nutrition of the tissue owing to a certain chemical action which they possessed which delayed the process of osmosis. Another theory was that they had the power of preventing the reversion of the cells to the simpler undifferentiated type which occurs in a malignant proliferation.

But to leave these vague and somewhat unconvincing theories for more definite histological facts. In 1901 Doutrelepon described the microscopical appearances of sections of lupus after exposure to the X-rays. A few foci of granulomatous cells were still present, and these were surrounded by a wall of leucocytes. The giant-cells in the foci were vacuolated and showed hyaline degeneration, and the broken-down cells were replaced by new fibrous tissue. He considered that a hyperæmia first occurred associated with an invasion of leucocytes, that this was followed by a degeneration of the granulomatous cells, and that these were replaced through a process of organisation, which resulted in the formation of a scar. Doutrelepon's description suggests an inflammatory reaction as the beneficial influence rather than a specific action of the rays on the diseased foci.

A more complete investigation on this subject was contributed by Scholtz in the beginning of 1902 under the heading of *The action of the Röntgen rays on healthy and diseased skin*. His experiments were carried out on the skin of pigs and rabbits, and also on human skin affected with Lupus vulgaris. He found that definite alterations did not appear on the skin till six or seven days after exposure to the rays, and that about this time the hair began to fall out. In the epidermis the cells became swollen and œdematous, vacuoles appeared in their protoplasm, and their nuclei became clumped and shrunken. Mitoses were rarely present, but in many of the cells division seemed to be going on without the formation of karyokinetic figures in the nuclei. In some places vesicles had begun to form on the epidermis.

In the corium œdema was also noticeable, and the collagen fibres were swollen and stained imperfectly; the elastin was affected, but not to the same extent. The connective-tissue cells showed similar changes to those of the epidermis; they were swollen, and their protoplasm had become homogeneous and vacuolated. The cells of the hair-follicles and sweat-coils were involved in the same manner. In the blood-vessels the endothelium was similarly affected. There was an inflammatory infiltration of cells with an increase of mast-cells around the blood-vessels, and masses of leucocytes had collected in the papillary layer immediately below the epidermis. From his observations on the skin of the pig Scholtz concluded that the X-rays had a specific action on the elements of the skin, causing a slow degeneration of the cells of the epidermis, hair-follicles, and glands, and also of the connective-tissue cells of the corium; and that the degeneration affected the nucleus as well as the protoplasm of the cells. The fibrous elements and muscles of the skin were also affected, but to a less extent. When the cellular degeneration reached a certain degree an inflammatory reaction was set up in which the blood-vessels were dilated, and there was an extravasation of serum and leucocytes; the latter seemed to act as phagocytes, and caused the complete destruction and resorption of the degenerated cells. In his examination of sections of lupus which had been rayed he found that the cells of the granuloma were swollen, and that between the plasma-cells there were large numbers of leucocytes. There were also a number of exceptionally large giant-cells with from 100 to 200 nuclei, which he believed to result from the exposure to the rays.

In the same year Carl Beck published a paper *On the Pathology of the Tissue Changes Caused by the Röntgen Rays*. In this he divided the changes produced by the rays into three stages or degrees, like the classical division of burns. In those of the first degree there were hyperæmia, infiltration of inflammatory cells, exfoliation in scales, and itching. There was also falling out of the hairs and degenerative changes in the more differentiated structures, such as hair-follicles, glands, and nails.

In the second degree vesiculation was present, and the inflammatory reaction was more acute. In the third degree there was an escharotic destruction of the irradiated tissue. He noted a thickening of the tunica intima of the blood-vessels, and he regarded the whole

process as the result of a chronic inflammation associated with colloidal degeneration of the elements of the tissue. This description is somewhat misleading, and seems to prove the existence of more or less inflammatory reaction from the first.

Pernet, in a note on the histology of X-rayed Lupus vulgaris, describes a degeneration and disintegration of the fibrous elements of the corium, in which the collagen is partly transformed into collastin; and also a degeneration of the cells of the hair-follicles, sebaceous glands, and coil-glands, and a destruction of the plasma-cells of the granuloma; but he makes no reference to an inflammatory reaction. Sequeira, in connection with rodent ulcer, found that the diseased cells underwent lysis, and sometimes a fatty degeneration, under the influence of the X-rays. Freund and many other observers have described an increase of pigment from exposure to the rays. This pigment is present in the deeper cells of the Malpighian layer of the epidermis, and in the connective-tissue cells of the superficial layer of the corium. There are two explanations which may be put forward to account for this increased pigmentation: either (1) it is the result of the direct action of the rays, in the same way as the pigmentation produced by the actinic and ultra-violet rays (it has been suggested that it was due to the presence of these latter rays, but this is not the case, as they are not able to pass through the glass of a Crookes' tube); or (2) it may be a sequela of inflammatory reaction.

Another curious effect of the X-rays, and one that it is difficult to explain satisfactorily, is the condition of the vessels in the ulcers and telangiectatic scars which they may produce. In an examination of sections of an X-ray ulcer I found that on the surface the epidermis had broken down and been replaced by *débris*, partly formed of disintegrating epidermal cells and partly of leucocytes. Beneath this, in the corium, the blood-vessels were dilated and almost cavernous, and in places their endothelial lining had given way. Gassmann explains this as the result of a vacuolated degeneration of the walls of the arteries and veins. As there was an infiltration of inflammatory cells around the vessels it would seem that, granted there were specific changes produced by the rays on the vessel-walls, which is more than probable, there was also added the factor of an acute inflammatory reaction. This is what one would expect, as it is after

the production of a severe dermatitis by the rays that these peculiar telangiectatic scars occur.

The most recent communication on this subject appeared in the *Journ. of Cut. Dis.*, by Pusey, of Chicago, with the title of *The rationale of and the indications for the therapeutic use of Röntgen rays*. This paper was read before the twenty-seventh annual meeting of the American Dermatological Association at Washington in May, 1903. In it he thus summarises the changes produced by the rays on the skin. First there is a hyperplasia of the prickle-cell layer, followed by a breaking up of the nuclei, a division without mitoses, and finally a degeneration of the cells. Similar changes occur in the cells of the hair-follicles and glands, leading to atrophy. In the corium there is an ordinary inflammatory reaction, with œdema and swelling of the fibrous elements. These are two changes which occur in the healthy skin, and they both point to an irritant of an unusual character which is capable of causing a degeneration of the more highly differentiated elements of the tissue, such as the hairs and glands, while it has at first a stimulating effect on the epidermis itself. In pathological states, such as carcinomata of the skin, he found that the diseased cells were destroyed and a fragmentation of their nuclei took place. The blood-vessels in the neighbourhood were affected, and an endarteritis seemed to have been produced which almost obliterated the lumina. These specific changes in the vessels did not precede those in the diseased epiblastic cells, showing that the latter were independent of inflammation. The healthy stroma around the cancerous infiltration was only slightly implicated, and was capable of recovery, as it is after exposure to the actinic rays.

From this somewhat disjointed survey, showing considerable unanimity on certain points and a variance of opinion on others, we may formulate the following tentative propositions as fairly representative of the present state of our knowledge of the subject:

(a) That the X-rays in small doses have a stimulating effect on the elements of the healthy skin.

(b) That in large doses, by long exposures, close proximity of the tube to the skin, or the employment of soft tubes,* the rays are capable

* This is leaving out of consideration the undecided problem of the possible difference in the type of the rays obtained from hard and soft tubes.

of devitalising the tissue-elements, interfering with the process of reproduction and causing their degeneration; and that this power is the result of a direct specific action of the rays.

(c) That the more highly differentiated structures, such as the hair-follicles, glands, nails, and blood-vessels, are more readily and severely affected by the rays than the less differentiated epidermal cells or the fibrous stroma of the corium.

(d) That pathologically altered cells, whether of epiblastic or mesoblastic origin, are far less resistant to the rays than healthy cells, and are devitalised with small doses of the rays; and that this destructive action on diseased elements may be taking place while the healthy elements in the neighbourhood, instead of having their vitality inhibited, may be stimulated to a process of repair.

(e) That the action of the rays is cumulative, and that when the cellular degeneration reaches a certain degree the toxic products of the breaking-down cells are capable of setting up an inflammatory reaction, which is a secondary phenomenon.

(f) That this inflammatory reaction is peculiar in that it occurs in a tissue the vitality of whose various elements has already been impaired by the action of the rays, and in that it is associated with greater destructive changes than those produced by the actinic rays, and is apt to lead to ulceration and necrosis, and is liable to be followed by an imperfect process of repair.

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CURRENT LITERATURE.

A CASE OF CHRONIC PURPURIC ERYTHEMA (EIGHT YEARS DURATION), WITH PIGMENTATION OF THE SKIN AND ENLARGEMENT OF LIVER AND SPLEEN. WILLIAM OSLER.
(*Journ. of Cut. Dis. including Syph.*, July, 1903).

PROF. W. OSLER records the case, with an illustration, of a man of good habits who for eight years from September, 1894, suffered from recurring erythemic purpura of the legs, leading to general pigmentation of the skin, with patchy erythema and purpura of the trunk and extremities, and enlargement of liver and spleen. There was a history of pneumonia in childhood, inflammatory rheumatism at twelve years of age, and a short attack of malaria nine years previously. The eruption began on the ankles, slowly involved the legs, then spread to the arms in crops. In 1900 pain was experienced in the joints, but without redness or swelling. An examination of the blood showed that the red blood-corpuscles numbered 5,000,000 per cubic millimetre, and the leucocytes 3000. There was 70 per cent. of hæmoglobin, and the coagulation time was three minutes. The relative proportion of the various leucocytes was:—Eosinophiles, 8 per cent.; small mononuclears, 12 per cent.; and polymorphonuclears, 74 per cent. Cultures from the blood were sterile. There was no fever. The inguinal glands enlarged progressively. The patient died in February, 1903, of pernicious malaria.

Prof. Osler remarks that recurrence of the eruption in crops is a common characteristic of the erythema group, and he has reported a number of instances of such recurrence during a period of years; but in this case scarcely a day passed without the appearance of fresh spots. Another feature was the extraordinary degree of pigmentation. The liver was probably the seat of hypertrophic cirrhosis, and was in direct association with the hæmorrhages, for recurrent purpura, purpuric erythema and urticaria, and sometimes quite large subcutaneous hæmorrhages, are occasionally met with in cirrhosis of the liver, generally in the later stages, and more frequently in the hypertrophic form. Prof. Osler thinks there is a group of cases in which recurring cutaneous hæmorrhage is the primary trouble, and leads to cirrhosis of the liver and enlargement of the spleen. In the remarkable condition known as hæmochromatosis there is a wide-spread destruction of red blood-corpuscles, leading to a pigmentation of the skin and a deposition of the iron-containing pigment in the internal organs, and in time to cirrhosis of

the liver and of the pancreas, and finally to a diabetes—the so-called bronzed diabetes.

T. C. F.

ERYTHEMA MARGINATUM PERSTANS. J. M. FINNY. (*Med. Press*, January 21st, 1903, p. 51. Two illustrations.)

THE patient whose case is described in this contribution was a young grocer's assistant aged 21. When he came under observation he was suffering from an erythematous eruption which consisted of pink-red coloured elevated lesions, some linear and curved in circles and segments, others forming spots and patches. These lesions were fairly symmetrically distributed, occupying both the back and front of the thorax, the abdomen, the arms, and the forearms to the back of the wrist, and the nates, thighs, and legs as far as the ankles. The palms, soles, fingers, and toes, and the dorsum of the feet were exempt, and the face, scalp, and upper part of the neck were quite free of the eruption. The glands in the groins, right axilla, and the mammary gland were enlarged. The eruption came out first in August, 1899, disappeared after two weeks' treatment, but returned later, and has persisted more or less since then. The patient stated that his legs were always worse than any other part of his body, and if exposed to cold while dressing would become very hard and of a blackish colour, and they were often swollen about the ankles and up to the knees. The eruption was very itchy, especially at night, just like nettle-rash. It varied greatly in intensity from time to time, and faded and changed its pattern, but always persisted. The general health of the patient gave no very definite clue to the cause of the eruption, except that he complained of indigestion.

The writer regards it as an instance of Erythema multiforme, and discusses the diagnosis from urticaria, psoriasis, eczema, and Dermatitis herpetiformis. (This case seems identical with two cases described by Colcott Fox in a paper read before the Clinical Society of London in November, 1880, under the heading of Erythema gyratum perstans.)

J. M. H. M.

DERMATOSES OCCURRING IN EXOPHTHALMIC GOITRE. NEVINS HYDE and E. L. McEWEN. (*Amer. Journ. of Med. Sci.*, June, 1903, p. 1000.)

ACCORDING to the writers of this paper, about 111 cases of exophthalmic goitre have been reported in which skin-lesions of a more or less serious type have co-existed. This list included 49 cases of hyperidrosis; 15 cases of pigmentary changes; 15 cases of myxoedema; 14 cases of simple oedema; 5 cases of sclerodermia, most of them generalised, a small proportion representing the circumscribed form; alopecia, often generalised, and vitiligo; lastly, one or two instances of telangiectases, purpura, urticaria, erythema, and one of hydrocystoma. The last case—namely, that of exophthalmic goitre with hydrocystoma—was contributed by the writers, and as far as they are aware is the first case of the sort to have been reported, though hyperidrosis has been frequently observed. They also report cases associated with telangiectases, cutaneous pruritus, and cutaneous pruritus and angioneurotic oedema.

The paper concludes with a survey of the literature on the subject and a full bibliography.

J. M. H. M.

IS ERYTHEMA PERNIO (CHILBLAINS) A TUBERCULAR EXANTHEM? G. E. PERMIN. (Reprint from *Hospitalstidende*, No. 18, 1903 Copenhagen.)

THE author, who is assistant at the Vejlefjord Sanatorium for Consumptives has taken the opportunity of investigating the association of chilblains with Phthisis pulmonum. He compared two groups of cases, viz. 90 tuberculous patients and 33 servant-maids employed at the sanatorium. In the first group 61 suffered from chilblains = 67·8 per cent. In the second, 11 had chilblains = 33 per cent. In 15 of the latter there were undoubted clinical signs of tubercle of the lungs, either recent or old. Of these 15 servants, 9 had chilblains,—that is, 60 per cent. Although the numbers are too small to draw definite conclusions from, yet it is interesting to note that the percentage of those suffering from chilblains is much the same among the tuberculous patients and the tuberculous servants. With regard to the 11 servants with chilblains, 9 had undoubted signs of Tuberculosis pulmonum. There was nothing definite as to tubercle of the lungs in the two other servants, but points connected with these cases made its existence probable. Of the 90 sanatorium patients, 53 were hereditarily predisposed, and 37 of these had chilblains. The age- and sex-incidence worked out as follows :

Age.	Males.		Females.		Males and females.	
	Chilblains.	Free.	Chilblains.	Free.	Chilblains.	Free.
1—15 . . .	—	—	1	—	1	—
16—25 . . .	13	10	17	4	30	14
26—40 . . .	12	7	13	6	25	13
41—60 . . .	3	2	2	—	5	2
Total . . .	28	19	33	10	61	29

— that is, 77 per cent. of the females and 59 per cent. of the males suffered. With regard to the hæmoglobin determination, five patients out of the aforementioned fifty-three showed it to be under 80 per cent.; all five had chilblains. In four others it was 80 per cent., and two of these had chilblains. Cyanosis, especially of the hands, was very frequent.

GEORGE PERNET.

BLACK CHROMIDROSIS WITH HYSTERICAL PARALYSIS. JAMES W. PUTNAM. (*New York Med. Journ.*, p. 26, July 4th, 1903.)

THE patient, a young woman of 19, suddenly developed an inky chromidrosis of portions of the skin of the face. The pigmentation first appeared one day when she was riding in a car, and her suspicions were aroused that her appearance presented something unusual by noticing that the other passengers were all staring at her. Both eyelids were first affected, and then the pigmentation ally spread over the upper portions of the cheeks. Two months afterwards

the skin of the eyelids and malar regions, and the upper portion of the nose and the edge of the mucous membranes of the lips, were inky black, but the sensation of the skin was normal.

She continued attending the classes where she was a student, which required great will force on her part, as her appearance always caused comment; but she gave up walking in the streets in the daytime, as she was frequently annoyed by the remarks of strangers. During the period the pigmentation lasted—nine months—she observed that whenever she was excited or tired the black areas increased in size and depth of colour, but when things went smoothly the areas became smaller and lighter.

The chromidrosis was preceded and also accompanied by amenorrhœa, which lasted altogether fourteen months, and during this time she was said to have had six attacks of "recurring hysterical paralysis."

Electric and other methods of treatment were unsuccessful, but the chromidrosis finally disappeared when she went to live in the country.

J. L. BUNCH.

PRIMARY CONGENITAL AND HEREDITARY KERATOSIS OF THE PALMS AND SOLES. T. DECROO. (*Journ. des Sci. Méd. de Lille*, No. 27, twenty-sixth year, July 4th, 1903, p. 11.)

THE patient, a married woman aged 26, came under observation with an attack of lymphangitis of the right leg. She was found to have a thickening of the epidermis of the palms and soles, and the lymphangitis was evidently due to infection through fissures in the thickened cuticle of the sole. The condition of the palms and soles had existed since birth, and on inquiry it was found that several other members of the family were similarly affected, viz. the paternal grandfather or grandmother (? one or both); the patient's own father and an uncle (his only brother); two of patient's brothers (three brothers and one sister being unaffected); the three sons of one of the affected brothers; one of the patient's own daughters (one other daughter being unaffected). The lesions presented by the patient were characteristic. The whole palmar surface of the hands and fingers showed a diffusely thickened, horny, epidermic layer of a reddish tinge. The lesions extended for a finger's breadth on to the internal and external borders of the hand, and were outlined with a well-defined erythematous zone of 1 cm. in breadth. On the fingers a slight thickening extended on to the dorsal surfaces, forming a sort of collar above the nail. The whole plantar surfaces of both feet showed similar lesions extending two fingers' breadth on to internal and external borders and completely encasing the heels; the thickening, however, was much more marked than on the palms, giving the skin a yellowish semi-transparent appearance, while here and there were deep fissures with white or greyish borders. The only subjective symptoms were an occasional slight itching and some burning pain at the seat of the fissures. The daughter of the patient had similar but less marked lesions, which had been noticed from birth. The epidermis of the palms was somewhat thickened, giving to the touch a feeling of a dry horny tissue, and of a yellow semi-transparent or amber appearance. On the feet the keratosis was more marked, producing a dry horny layer with light fissuring here and there. This child was in less robust health, was smaller, and less well developed than the younger unaffected sister.

In all the other members of the family the lesions were exactly of the same character, and limited to the hands and feet, and existing since birth.

H. G. ADAMSON.

LICHEN PLANUS DEVELOPED CONCURRENTLY WITH SCABIES, AND LICHENOID TRANSFORMATION OF SCRATCH-MARKS. HALLOPEAU and JOMIER. (*Annales de Derm. et de Syph.*, vol. iv, No. 4, April, 1903, p. 352.)

HALLOPEAU and Jomier showed at the Société de Dermatologie et de Syphiligraphie a case of "Lichen planus developing concurrently with scabies." The writer recalls a similar case, of which the following is a brief note:—The patient, a medical man, had had for three weeks intense itching of the limbs and trunk with an eruption of the skin. When first seen there was typical Lichen planus. The wrists, forearms, lower part of the arms, and upper part of thighs were covered with thickly set, flat, red, angular papules typical of Lichen planus, and there were also whitish patches in the mouth—palate and inner surface of cheeks. In addition there were vesicles and burrows of scabies on the hands and fingers, and a few scattered broken vesicles among the papules on the thighs. The acarus was found in the burrows on the fingers. There was a history of the patient's coachman having had an itchy eruption of the hands some weeks before. The scabies was readily cured by sulphur ointment, etc. The Lichen planus remained. It persisted for three or four months, and finally disappeared.

Hallopeau and Jomier threw out the suggestion that the "pruritus provoked by the acarus had played a similar rôle to the pre-eruptive pruritus of the partisans of the nervous theory of lichen." As a simpler hypothesis they suggested that the scabies had placed the skin of the patient in a condition of less resistance.

It is well known that in a case of generalised Lichen planus local injury or local irritation has some influence in determining the point of chief manifestation; instances of this are pressure of the garters or of the waistband, presence of varicose veins, which induce both irritation and lowered vitality, scratch-marks, etc. It seems possible that the irritation from the scratching in these cases may have in a similar manner determined the outbreak of Lichen planus in a predisposed person.

In Hallopeau's case the linear distribution of lesions along scratch-marks was regarded by them as an argument in favour of the parasitic origin of lichen.*

H. G. ADAMSON.

CONGENITAL DYSKERATOSES AND THEIR MORBID ASSOCIATIONS. LENGLET. (*Annales de Derm. et de Syph.*, vol. iv, No. 5, May, 1903, p. 372.)

LENGLET, referring to a recent article by Meneau entitled "Fœtal Ichthyosis in its Relations to Ordinary Ichthyosis," expresses surprise that any attempt should now be made to return to the chaos of the earlier history of ichthyosis. The

* Cf. case shown by West, *Brit. Journ. of Derm.*, vol. ix, p. 162, in which Lichen planus lesions occurred along scratch-marks from a cat, there having been no eruption previous to the scratching.

tendency of writers at the present time is rather to draw a distinction between ordinary ichthyosis and foetal ichthyosis; in describing fresh cases of foetal dyskeratosis, new designations are sought rather than the application indiscriminately of the term "ichthyosis."

Until recent years it has been the custom to distinguish only three types of congenital dyskeratosis, viz. (1) ichthyosis palmaris et plantaris, (2) ordinary ichthyosis, (3) foetal ichthyosis; around these three forms have been grouped somewhat at hazard all sorts of clinical varieties. From this confusion Brocq has disengaged a new type, which he has called "*Érythrodermie congénitale ichthyosiforme avec hyperépidermotrophie*," characterised by erythrodermia as a marked feature, with hyperkeratosis of the flexures sometimes associated with keratodermia of the palms and soles, and with bullous lesions and affections of the epidermal appendages and glands. Other authors have published cases which they have regarded as an attenuated form of foetal ichthyosis, or have distinguished altogether from ichthyosis, cases which may all be included under the term suggested by Grass and Török of "*Exfoliation lamelleuse des nouveau-nés*." While Meneau attempts to establish between all the forms described by various authors sufficient analogy to justify the fusion of all these varieties, Lenglet maintains that the modern tendency rightly is to distinguish these forms of congenital anomalies; and he endeavours to prove that among the mass of cases described there are a number of distinct clinical types which are related to one another by "transitional forms." He distinguishes the following chief groups:

1. The lamellar desquamation of the new-born of Grass and Török.
2. Foetal ichthyosis properly so called.
3. Congenital ichthyosiform erythrodermia of Brocq.
4. Keratodermia of palms and soles, and their associations.
5. Atrophic lesions, circumscribed and generalised.
6. Types of bullous lesions complicated by one of the preceding morbid types.
7. Ordinary ichthyosis.

He carefully describes each of these varieties, and discusses their pathogeny and their relationship with one another. He quotes many cases of congenital dyskeratoses described under the term "ichthyosis," or under various other names, and places each of them in one or other of these groups. He distinguishes ordinary ichthyosis (*Ichthyose vulgaire*) from all of the other forms, which he regards as the antipodes of true ichthyosis (*Ichthyoses interverties*). Ordinary ichthyosis affects the whole integument with the exception of the flexures and the palms and soles; the foetal types are frequently associated with keratosis of the palms and soles, and particularly affect the flexures. Hyperidrosis, so frequent in the opposed types, is absent in ichthyosis. Ichthyosis does not attack the face; the congenital ichthyosiform erythrodermia, and lamellar exfoliations of the new-born constantly affect that part. In ichthyosis the hairs are defective in those parts where they are normally well developed; in Brocq's ichthyosiform erythrodermias hyperkeratosed areas are often traversed by numerous hairs. In ichthyosis there are never lesions of the mucous membranes, while in the other dermatoses they are not unusual.

The differentiation of ordinary ichthyosis from foetal ichthyosis and the allied group of lamellar desquamation of the new-born is not, however, so clearly demonstrated by Lenglet. He suggests that their pathogeny is different, the lamellar desquamation being probably the result of persistence of the normal, epi-

trichium, and foetal ichthyosis of the non-differentiation of the epidermic cells to form the two superposed epithelial layers. Ichthyosis, on the other hand, is regarded as an affection of the subjacent epithelium without relation to the epitrichium. The *rationale* of the separation of these two groups from ordinary ichthyosis is, however, not made so clear as that of the separation of the "erythrodermia" types from ichthyosis.

The author indicates by means of a chart, according to the graphic method of Brocq, the various relationships between these groups of congenital dermatoses.

H. G. ADAMSON.

CONTRIBUTION TO THE STUDY OF HIDROCYSTOMA (with a note on *Granulosis rubra nasi*). AUG. LEBEL. (*Annales de Derm. et de Syph.*, vol. iv, No. 4, April, 1903, p. 273.)

THE clinical features of Hidrocystoma are sufficiently distinctive. That the disease is an affection of the sweat-apparatus is recognised by all, but the exact relation of the cystic formation to the sweat-apparatus is not yet clearly established. By Robinson, who first described the disease, they were regarded as a dilatation of the excretory part of the gland due to an obstruction of the duct; and this view has been accepted by the majority of observers. Adam, however, believed the cysts to arise in the glomerular portion, and regarded them as due to hypertrophy of the glands without corresponding enlargement of the excretory duct to carry off the excessive secretion consequent on the hypertrophy. In criticising Adam's statements Lebel points out that the common situation of origin of the cysts is just where the secreting portion joins the excretory duct, so that the cyst might appear to be in the gland itself without being actually connected with the secretory portion; and he insists upon the necessity of examining serial sections in order to determine whether the excretory duct still remains in connection with the cyst. In ordinary sections it is impossible to say whether the ducts above the cysts are in connection with these or with normal glomeruli. In Lebel's serial sections he was unable to trace any ducts connecting the cysts with the superficial epidermis. Jarisch's examination of a case by serial section gave a like result (Jarisch, *Congrès de Gratz*, 1895, p. 313).

Lebel holds that the dilatation is due to obstruction of the secretory duct, if not to its entire disappearance. Such an obstruction could lead either to dilatation of the weaker walled duct or to the glomeruli situated in a less resisting structure. Intermittent pressure from alternate distension and absorption would account for the proliferation of the epithelium of the cyst wall. The external pressure, or even, as Jarisch maintains, the total disappearance of the external portion of the excretory duct, is possibly due to an inflammatory infiltration around the duct. Microscopically, inflammatory foci have been observed, though hitherto regarded as secondary. The predilection of the disease for the face in persons exposed to extreme heat is in accord with an inflammatory cause. The "gangcysten" observed by Unna in old favus lesions and in scarred lupus lesions can be similarly explained. Lebel also cites certain cases of *Granulosis rubra nasi* in which cystic dilatations have been observed. Hyperidrosis is usually present in this disease, and an inflammatory infiltration is found around the sweat-ducts. He records a case of hyperidrosis localised to the nose, and associated with slight atrophic scarring and Hidrocystoma of that region, in a patient whose daughter

had *Granulosis rubra nasi*. Although Jadassohn has drawn a distinction between Hidrocystoma and Granulosis rubra nasi, Lebel thinks that the occasional formation of cysts in the latter disease throws light upon their method of formation in Hidrocystoma. In both of these affections there is an inflammatory infiltration around the sweat-ducts which may lead to pressure on, or to actual obliteration of, the excretory duct, and so cause retention cysts.

H. G. ADAMSON.

"WHITE-SPOT DISEASE." JAMES C. JOHNSTON and SAMUEL SHERWELL.
(*Journ. of Cut. Dis. including Syph.*, July, 1903.)

A neurotic woman, aged 26 years, with poor physical development, but otherwise enjoying fairly good health, was first attacked with a peculiar eruption at the age of thirteen. Though the lesions gradually multiplied, they changed but little individually. On the anterior surface of the chest, extending from the outer third of the left clavicular region to the middle third of the right, and from the shoulder girdle to the upper margin of the breasts, were spots arranged in rows, following the skin lines across the chest, and roughly corresponding to the distribution of the vascular supply. The lesions range from a pin-head upwards (size not given.) They are a striking dead-white snow-colour, without subjective symptoms, very slightly raised, smooth to touch, sharp and irregular in outline, without trace of inflammatory areola, and without much tendency to coalescence. Certain of them have the appearance of a central punctum. In course of time certain spots involute, a thin scale separates, and punctate and striate atrophy results, corresponding exactly in size to original spot.

Histologically the lesion proved to be a pure degeneration, limited to the papillary body and the upper portion of the reticular layer. The collagen was replaced by a granular material which had lost its characteristic acidophile staining tendency. The elastic tissue was broken up into short lengths of fibre or granules, taking the acid orcein stain abnormally deeply; and, where the process was most advanced, the elastic network covering the papillæ had completely disappeared, and in other places showed beginning rupture. Some of the vessels preserved at the base of the papillary body were often dilated, and the endothelial cells swollen. An irregular lymphocytic infiltration sheathed the vessels in places, and in others seemed independent. Mononuclear cells were rare. Proliferated and swollen fibroblasts were found here and there. Epithelial changes were secondary.

The authors surmise this degeneration was due to obliteration of the smaller vessels of the reticular plexus, possibly from blocking by swollen endothelium. A satisfactory result in treatment appears to have been produced by the use of an irritant strong enough to set up an active inflammation and so carry away the degenerated *débris*. This was accomplished by the application of a saturated solution of resorcin in alcohol applied three or four times daily. For another case Johnston suggests the application of crystals of trichloracetic acid, which McGuire used for xanthelasma of the lids.

The case is identified with the disease recorded in a girl of eleven years by Westberg (*Monatsh. f. prakt. Derm.*, 1901, vol. xxxiii, p. 355, and epitomised *Brit. Journ. Derm.*). Johnston also refers to a case exhibited by F. H. Montgomery in 1901 before the American Dermatological Association, and generally considered as a peculiar form of morphea.

[The reporter recalls several cases which may be of a similar character: one described by Startin, sen., as *Morphœa guttata*, another in a young lady under the care of Tilbury Fox, and one or more exhibited at the Dermatological Society of London; but it was thought that there was not any histological investigation made in these cases. It is certain that very similar spots may occur in morphœa. Mr. Hutchinson has figured grouped spots of morphœa occurring beneath the clavicles. The case of guttate scleroderma reported by Perry (*Brit. Journ. of Derm.*, vol. x, 1898, p. 54) is also interesting in this connection.]

T. C. F.

ON ELEPHANTIASIS LYMPHANGIECTATICA CONGENITA; a Contribution to the Knowledge of the Diseases of the Lymphatic Vessels. E. VOLLMER. (*Archiv f. Dermat. u. Syph.*, June, 1903, lxxv, p. 345. Four plates.)

ELEPHANTIASIS lymphangiectatica congenita is a very rare congenital anomaly of the skin. In the majority of cases the infants affected by it have been still-born, or have died soon after birth. In only a few instances have they survived and come under clinical observation; and in such cases the area of skin implicated by the disease has been small. Vollmer, in this contribution, describes a case in detail which he had the opportunity of studying. The subject of it was a boy aged 5, who presented on examination a soft discoloured swelling of the skin occupying the whole of the right cheek from the ear to the nose and down to the border of the jaw. Besides this lesion there was a tumour-mass in the scalp, extending up for about 5 cm. from the ear; and there were pigmented patches on the right side of the neck, right shoulder, and upper arm. To the touch the swelling on the face had a peculiar spongy feeling. It had a mottled appearance owing to the presence of brownish pigmented patches enclosing various areas of normally coloured skin. The tumour-mass was successfully excised by means of a linear incision extending from the ear to the chin.

A microscopical examination revealed a marked hypertrophy of the white fibrous tissue of the corium and subcutaneous tissue, with a new formation of fibrous elements like a fibroma. This fibrous stroma was broken up by dilated lymphatic spaces and channels, containing leucocytes and plasma-cells. Many of the deeper cells of the Malpighian layer were pigmented, and pigment granules were present in a number of the connective-tissue spindles in the upper part of the corium. The paper is illustrated by photographs of the patient and drawings of the microscopical appearances.

J. M. H. M.

ON MELANOBLASTS, "HEMICHROMASIE," AND THE EPITHELIAL FIBRILS IN BROAD CONDYLOMATA. S. EHLMANN and M. OPPENHEIM. (*Archiv f. Dermat. u. Syph.*, June, 1903, lxxv., p. 323. Three plates.)

IN the lesions known as "broad or flat condylomata," which generally occur in the active stage of syphilis and are simply hypertrophied mucous patches, the authors have found suitable material for the study of the origin of pigment, a subject with which the name of one of them is so intimately connected. In these lesions not only is there a marked acanthosis, but the epidermal cells are enlarged

and the melanin-containing cells or "melanoblasts" are greatly increased; and, in consequence, these condylomata are eminently suited for such a histological study. The tissue examined in this instance was excised from the inner surfaces of the large and small labia of a brunette, and the condylomata varied in size from a pea to a hazel-nut. The tissue was fixed and hardened in alcohol, and cut in paraffin, and the sections, which varied from 3 to 6 μ in thickness, were stained by Kromayer's modification of Weigert's method for the demonstration of the epithelial fibrils, and by several other methods which are not so well known. Various other tissues have been examined by the authors in this connection, such as pigmented nævi, ephelides, negro-skin, scalp, etc., but in none of them was such an excellent demonstration of the melanoblasts obtained as in mucous patches.

In a series of drawings and sections stained by these methods the melanoblasts are seen at the border of the epidermis, and also between the prickle-cells in its neighbourhood. These cells the authors regard as similar to the pigmented cells of the corium, and as having a similar origin. Besides the melanoblasts, the prickle-cells of the epidermis have here and there taken up the melanin granules from the melanoblasts. The increase of pigment in the condyloma is chiefly situated at the periphery, and both the melanoblasts and the pigment-containing epithelial cells are increased there, while in the centre of the lesion there is a diminution of pigment, or it is wholly absent. According to the writers, the melanoblasts are peculiar mesoblastic cells taking their origin in the mesoderm, and are neither simply a deposit of granules in the intercellular spaces of the epithelium, nor an optical illusion; nor are they leucocytes or ordinary connective-tissue cells. (Unna suggested that they were not cells, but simply a deposit of pigment granules in the interepithelial lymph-space surrounding a leucocyte.) By "hemichromasie" the writers mean the power which many of the epithelial cells in flat condylomata and in a number of other pathological conditions exhibit of being deeply and irregularly stained in one part of the cell by such dyes as methylene blue and fuchsin in Weigert's method. The lower half of the cell is the part generally affected. It stains very deeply, while in the upper portion of the cell, which is faintly stained, the spongioplasm and epithelial fibrils are more easily detected. This appearance occurs in any condition where the drying and cornification of the cell is interfered with, and is the result of the presence of moisture.

A very complete bibliography of the literature on the subject is appended.

(The views stated in this paper are similar to those put forward by Ehrmann in 1886 in the *Verteljahrsschr. f. Derm. u. Syph.*, xiii, p. 57; these have been strongly opposed by Karg and Kölliker, who believe that the pigment-bearing cells are not peculiar mesoblastic cells, but ordinary connective-tissue cells, and by Delépine in this country, who considers that the melanin is elaborated by the epithelial cells, and is not a derivative of hæmoglobin.)

J. M. H. M.

CONTRIBUTION TO THE HISTOLOGY OF SOFT NÆVI. OTTO SACHS. (*Archiv f. Dermat. u. Syph.*, July, 1903, lxvi, p. 101. Two plates.)

IN a somewhat elaborate paper the author describes the results of a histological examination of several nævi excised from a girl aged 8 years, in Breslau. The

child had a variety of nævoid growths. On the tip of the little finger of the right hand there was an excrescence resembling a raspberry in colour and in appearance. It occupied the whole of the dorsum of the ungual phalanx, and the nail was absent. There were several smaller linear nævi on the other fingers of the same hand. In the right axilla there was a large rose-red nævoid patch extending from the lower border of the axilla as far as the middle of the upper arm. This patch was raised, fissured, and œdematous. It was soft to the touch, and the surface was rough and verrucose. The fissures were moist. Smaller verrucose nævi were present in the right gluteal region and on the toe of the right foot. These lesions were noticed by the mother soon after birth.

A very careful histological examination was made. The tissue was fixed and hardened in a number of solutions, sections were cut both in celloidin and paraffin, and stained with the usual protoplasm stains and those suitable for the demonstration of the fibrous elements. The fat in the tissue was specially stained with Sudan III.

An examination of the raspberry-like lesion on the finger showed a condition of the epidermis not unlike that present in *Condyloma acuminatum*. There was also an inflammatory infiltration in the corium consisting of leucocytes, mast-cells, plasma-cells, and connective-tissue cells, and a dilatation of the blood-vessels of the papillary and subpapillary layers. The lesion in the axilla was more interesting. With the low power it had the appearance of a soft non-pigmented nævi, with an infiltration of cells in the upper part of the corium which were grouped like nævus-cells, and an inflammatory disturbance in the pars reticularis with a dilatation of the blood-vessels and lymphatics, and foci of inflammatory cells around them. With the high power the epidermis was found to be distinctly œdematous, the cells being swollen and the interepithelial lymphatic spaces dilated. The cells in the papillary and subpapillary layers, which had appeared as ordinary nævus-cells, were now found to be filled with fat granules like the xanthoma-cells. With Sudan III the fat stained exactly the same as that of the subcutaneous tissue. These xanthoma-like cells had a spongy honeycomb-like appearance from the fat, and their nuclei were in many cases placed eccentrically. In the illustration they suggested the cells of a sebaceous gland.

The writer does not consider these cells to be simply nævus-cells which have undergone fatty degeneration, but believes them to be peculiar embryonic deposits, nor does he agree with Unna as to the epidermal origin of nævus-cells. The paper is illustrated by excellent photographs of the patient and drawings of microscopical sections, and a full bibliography is appended.

(The lesion in the axilla corresponds with what has been described as *Nævus lipomatodes*, and has been regarded as the result of a fatty degeneration of the nævus-cells.)

J. M. H. M.

CONTRIBUTION TO THE KNOWLEDGE OF REGIONAL AND LINEAR NÆVI ("Systematisierten Nævi"). P. STRASSER. (*Archiv f. Dermat. u. Syph.*, July, 1903, lxvi, p. 21. One plate.)

SINCE von Bärensprung first described linear and regional nævi in 1863, a large literature has collected round the subject cases have been reported in which

almost every region of the body has been affected, and an endless variety in the type and arrangement of the lesions have been recorded. Various hypotheses have been put forward to account for the peculiarities of the arrangement, and there has been much discussion regarding the nature of the cells which infiltrate the corium in these lesions; yet in spite of this considerable literature the cause of the linear and regional distribution of *nævi* is still a subject for conjecture, and the nature of the cells, whether they are of epiblastic or mesoblastic origin, a subject for controversy. It is only by utilising every opportunity of studying and reporting such cases that we may hope to have these problems finally settled.

The case here recorded is an interesting one, and occurred in the clinique of Professor Vierordt, of Heidelberg. The patient was a girl who came under the observation of the writer when she was eight years old, presenting a large *nævus* affecting her head and neck and one side of her body. At birth the skin appeared to be perfectly healthy, and it was not until she was seven months old that any abnormality was detected. (This is a point of interest and importance, as in a considerable number of these cases it is not till several months after birth that the *nævus* begins to be noticeable.) The lesion first appeared on the scalp, where it was associated with weeping crusted patches, which were probably independent of the *nævoid* condition. On examination the scalp presented a number of verrucose pigmented patches, varying in size from a two- to a five-mark piece. Over the patches the hair was fine and unpigmented, like lanugo-hair. In the healthy skin between the patches the hair was brown in colour, and this gave the scalp a curious piebald appearance. Beside these patches there were two linear lesions on the scalp. One of those extended from the vertex of the scalp and curved forwards on each side of the forehead as far as the outer ends of the eyebrows. It was in the form of a verrucose stripe, about 3 cm. in breadth. A corresponding stripe was present at the back of the scalp, and extended from behind the other one at the vertex, downwards on each side behind the ears, to the nape of the neck. There was also a small linear patch which stretched from the left eyelid upwards and backwards to the scalp.

Verrucose pigmented patches with no definite arrangement were present on both sides of the face and neck, and on the ears. At the left angle of the mouth there was a papillomatous lesion like a *Condyloma acuminatum*. The mucous membrane of the tongue was affected, and near the middle line the papillæ were much hypertrophied. Below the clavicles the *nævus* became unilateral, and affected only the left side. Warty pigmented patches, some having a brownish-blue tinge, were present on the left side of the trunk. On the front of the left arm verrucose pigmented stripes occurred, which tended to run parallel to the axis of the limb, and were specially noticeable near the axilla and below the elbow. The skin of the palm of the hand was warty, but the most marked verrucosity was present on the back of the fingers of the left hand in the regions which become so characteristically affected in *Pityriasis rubra pilaris*. On the left labium majus there was a condylomatous lesion similar to that at the angle of the mouth. The left leg was affected in a manner somewhat similar to the trunk. The right side of the body was unaffected, with the exception of a few isolated warts situated on the right arm.

The writer discussed at considerable length the various hypotheses which have been suggested to explain the arrangement of these *nævi*, such as their supposed

relation to the distribution of the cutaneous nerves, to Voigt's lines, to the spinal ganglia, to the blood-vessels and lymphatics, and to the hair-lines or whorls. He pointed out that this case could not be completely explained by any of these hypotheses, though portions of the lesions might be.

The patient was treated with thyroid extract, and improved considerably under it.

The paper is illustrated by a photograph of the patient and several diagrams showing the distribution of the lesions, and a short bibliography is added.

J. M. H. M.

A CASE OF XANTHOMA TUBEROSUM MULTIPLEX, WITH REMARKS ON XANTHOMA IN GENERAL. L. LEVEN. (*Archiv f. Dermat. u. Syph.*, July, 1903, lxvi, p. 61.)

IN this contribution Leven describes a typical case of Xanthoma diabeticorum which occurred in a man aged 43. Nodules of xanthoma were present in the usual situations, such as the extensor aspect of the elbows and inner side of the thighs; and the urine contained a considerable percentage of sugar. A histological examination was made of one of the lesions. The epidermis was found to be unaltered, the papillary body flattened, and the xanthomatous mass situated in the reticular layer to be made up of connective-tissue cells, which were spindle-shaped at the periphery, were round nearer the centre, and in the centre were replaced by fat. Xanthoma-cells were also present; these the writer regarded as ordinary connective-tissue cells which had become infiltrated with fat owing to a degenerative process resulting from an interference with the proper nutrition of the part. The writer then discusses the question of the identity of the symptomatic xanthomata, such as those which occur in association with diabetes and disturbances of the liver, with the so-called idiopathic Xanthoma tuberosum multiplex, for which no definite cause can be assigned. He concludes that although the symptomatic type of xanthoma may be distinguished clinically from the idiopathic variety, by the form, localisation, and capacity of spontaneous involution exhibited by the lesions, still the histology of these two types is indistinguishable. On the other hand, he admits, with most other writers, that these forms of xanthoma belong to a totally different category from the so-called Xanthoma palpebrarum, which is not a xanthoma in the proper sense of the term.

J. M. H. M.

FURTHER CONTRIBUTION TO THE PATHOLOGY OF THE SO-CALLED SARCOMA MULTIPLEX PIGMENTOSUM HÆMORRHAGICUM IDIOPATHICUM (KAPOSI). J. SELLEI. (*Archiv f. Dermat. u. Syph.*, July, 1903, lxvi, p. 41. One plate.)

IN this paper the writer discusses with considerable detail the literature on the pathology of the Sarcoma multiplex pigmentosum hæmorrhagicum idiopathicum of Kaposi. He briefly describes three cases which form the basis of his histological examination.

Two of those cases he has already recorded in the *Monats. f. prakt. Dermat.*, 1900, xxxi, and 1902, xxxiv. He found in all his specimens a chronic inflammatory infiltration consisting of fibroblasts, plasma-cells, leucocytes, and

mast-cells, which suggested far more the infiltration found in the "infective granulomata" than that of the sarcomata. He concludes that this peculiar affection should be placed in the group of the infectious granulomata, and should not be regarded as a sarcoma. He is supported in this view by Gottheil, Cholin, Kudisch, Schwimmer, and others; but a number of other writers, such as Iwanoff, Jordan, Pelagatti, Philippon, and Bernhardt, maintain that it is a variety of sarcoma.

J. M. M. H.

A CASE OF MOLLUSCUM CONTAGIOSUM IN A SYPHILITIC CURED BY THE INTRA-MUSCULAR INJECTION OF MERCURY. E. KISTYAKOVSKI. (*Russ. Journ. Skin and Ven. Dis.*, February, 1903, p. 155.)

THE local application of mercury has long been used with success in many skin diseases, both syphilitic and non-syphilitic. Recently cases have been reported where mercury has had a similar effect on various skin diseases when administered by intra-muscular injection. Most of the cases have occurred in patients who have been suffering at the same time from syphilis. The author quotes a large number of instances, reported by various dermatologists, where lupus, lichen planus, sycosis, psoriasis, seborrhoic eczema, pityriasis rosea, and other diseases of the skin have been improved or cured by the internal administration of mercury.

In October, 1901, the author had a patient, a young man, with a primary sore on the prepuce, general enlargement of the lymphatic glands, syphilitic alopecia, and papules on the trunk and on the palms. On the inner surface of the right thigh in the upper third were six typical mollusca contagiosa, of a rose colour, and with a depression in the centre. According to the patient's account the mollusca appeared almost simultaneously with the other skin lesions.

Under the influence of intra-muscular injections of corrosive sublimate, and later of salicylate of mercury, the syphilitic manifestations retrogressed, leaving some pigmentation. A red areola appeared around each molluscum and pus formed in the centre, and they disappeared, leaving behind a slightly pigmented scar. The two remaining mollusca disappeared in the same way after a continuance of the injections, benzoate of mercury being employed; and in February, 1902, they had completely gone.

WILLMOTT EVANS.

CALOMEL IN THE TREATMENT OF ULCUS CRURIS. G. I. MESHCHERSKI. (*Russ. Journ. of Skin and Ven. Dis.*, May, 1903, p. 678.)

A WOMAN, 61 years of age, had suffered for thirty years from varicose veins of the left leg, leading to elephantiasis and ulceration. She had had treatment for seven years, but without benefit. On admission her left leg was found to be greatly enlarged in its lower half, and anteriorly the skin was dull reddish and in part pigmented. In the centre of this area were two ulcers, the upper as large as the palm of the hand, and the lower as large as a shilling. Both ulcers were typically indolent, with ill-formed granulations. There was no syphilitic history, and as all the signs were typical of a chronic simple ulcer of the leg, there was no possible doubt as to the diagnosis.

Professor Pospelov and his pupils have had much success in the treatment of elephantiasis by injections of calomel, and therefore Professor Alexis Ivanov suggested to Dr. Meshcherski to try this treatment. The only local application was a 3 per cent. solution of boric acid.

During the patient's stay in the hospital she had four injections of calomel, each $\frac{1}{2}$ gm. The ulcers, which had resisted treatment for seven years, cicatrised completely in four weeks.

WILLMOTT EVANS.

VACCINIA OF THE FEMALE GENITALIA. LÖWENBACH and BRANDWEINER. (*Monatsh. f. p. Derm.*, vol. xxxvi, 1903, No. 1, p. 5. With coloured plate.)

THE authors relate four cases of accidental vaccinia of the female genitalia from Professor Neumann's clinic (Vienna). The condition is an unusual one, and of interest from the differential diagnostic point of view. In Case 1 the mother had wiped her vulva with the same piece of linen she had used just before to wipe the arm of her recently vaccinated infant. In Case 2 the recently vaccinated child slept in the same bed as the mother. In Case 3 the infection was conveyed from the child's arm by scratching, the mother suffering from pruritus vulvæ as a result of a vaginal discharge. In Case 4 the family medical attendant made a vaginal examination of the mother, after dressing her recently vaccinated child's arm, without previously washing his hands. Other cases culled from literature are given, with bibliography of the subject. Some instances of accidental vaccinia are also mentioned. In one of these the father accidentally inoculated his penis with his fingers after dressing his recently vaccinated child's arm, and soon after infected his wife, who developed vaccinal lesions about the labia majora and urethral orifice (Lamb's cases, *Lancet*, 1898, cited by Löwenbach and Brandweiner).

GEORGE PERNET.

TRICHOMYCOSIS CAPILLITIL. R. WINTERNITZ. (*Archiv f. Dermat. u. Syph.*, July, 1903, lxvi, p. 81. One plate.)

IN this contribution the writer describes an affection of the hairs which is closely similar to Lepothrix (*Palmellina* of Pick) in its clinical appearances, but which he claims to be different, and to be produced by a different micro-organism. The disease appeared on a fair-haired boy, aged 11, in the form of dark brown patches of hair on his scalp. The largest patch was about the size of a shilling. In the affected areas the hairs were thickened for about 3 to 5 mm. from the free ends, and smaller thickenings could be detected below this. The thickening was in the form of an irregularly margined or lobed concretion of a dark brown colour. The disease began several weeks after the boy had had his hair cut.

A microscopical examination of an epilated hair showed that the concretion was situated on the surface of the hair between the cuticle and the root-sheath, and here and there the cuticle had become lifted up, and it was in contact with the hair-cortex. On staining with Loeffler's methylene blue masses of bacilli were found in the concretion. These grew on agar in from thirty-six to forty-eight hours, in the form of pin-point- to pin-head-sized colonies, which were sharply

margined, and at first were white and transparent, but as the medium dried became yellowish or brownish in colour. Cover-slip preparations from the culture, stained with methylene blue, showed the bacilli. These were straight or slightly bent, with frequently spores at each end, and measured $1.8\ \mu$ to $3.6\ \mu$ in length, and $0.6\ \mu$ to $0.9\ \mu$ in breadth. They were variously arranged end to end, forming threads, or in clusters.

The condition was evidently different from Piedra, which is due to a fungus with mycelium and spores. In Trichomycosis palmellina a diplococcus enclosed in a capsule has been described by Eisner and Colombini; also cultivated diplococci. On account of the bacilli the writer regards this as a different affection from Lepothrix. Payne, however, has described bacilli in this affection, so that there are possibly several varieties.

J. M. H. M.

CONTRIBUTION TO OUR KNOWLEDGE OF THE HAIR-SYSTEM OF MAN. F. PINKUS. (*Dermatologische Zeitschrift*, Bd. x, p. 225, 1903.)

IN order to understand this interesting paper it is necessary to refer to the former communication by the same author, abstracted in this Journal, vol. xv, p. 75. The paper referred to contained a description of an appendage to the skin called by the author "hair-discs," and hitherto undescribed. In this new communication he describes further investigations into the nature of these bodies, and shows that by appropriate staining—namely, by the vital methylene blue method and by palladium chloride—these discs may be seen to be quite peculiarly richly supplied with nerves derived by the bifurcation of the nerve supplying the hair-follicle with which they lie in such close relation. He then draws attention to the fact that, although they have at present only been found in the skin of man, they bear a close anatomical resemblance to the touch-plates already known to exist in the skin of *Hatteria punctata* (a peculiar lizard found in Australia) and in the crocodile. He rightly points out that the relationship of the two organs is not proved by their anatomical similarity, but believes that the hair-disc is a structure intimately connected with the sensory functions of the skin.

It is impossible in a short abstract to give the whole of this paper, which would seem to be of great importance, and those interested should refer to the original papers. A more detailed account is promised later.

A. W.

REPORTS ON RADIOTHERAPY. M. F. ENGMAN. (*Interstate Med. Journ.*, July, 1903, p. 377.)

1. *Cure of epithelioma of the tongue.*—The epithelioma was situated upon the right side of the tongue, three inches back from the tip. It consisted of a flat, oval, raised, indurated plaque about the size of a dime. It had a distinct hard border, which was slightly raised, and at the centre of the lesion there was a deep fissure, but no ulceration. It had been gradually increasing in size for some months, and was painful when the tongue was moved. No glandular enlargement was detected. The plaque was accessible to the X-rays when the tongue was drawn out. The patient was placed in the reclining position upon the left side. A

special lead mask was placed over the face, with an opening slightly larger than the lesion, the part over the mouth being so moulded as to fit into the opening, and at the same time to assist in holding the tongue in place. A moderately hard tube was used at a distance of three to six inches, and exposures of from five to fifteen minutes were given every other day for twelve days, and then daily. After the first series of exposures of twelve days the mucous membrane of the exposed part became gradually whitened, and looked as if it had been cauterised with nitrate of silver. The treatment was in consequence stopped for a week till the tissue had regained its normal appearance, and the exposures were then resumed. Two other series of exposures were given. In the last series the tube was placed at a distance of only three inches. This caused the lesion to have a dirty charred look, which was succeeded in two weeks by a severe reaction. A few days later the cauterised tissue sloughed away and the wound quickly healed, and in about a month was replaced by a slight scar as smooth and soft as the rest of the tongue. A year has elapsed without any sign of recurrence.

2. *Axillary hyperidrosis*.—Engman here reports a case of a man aged 25 years, who suffered from severe hyperidrosis of both axillæ, which was markedly benefited by exposure to the X-rays. The patient had tried the usual remedies, such as formalin and chromic acid, with only slight and temporary benefit. The axillæ were then submitted to the X-rays through a hole in a sheet of lead-foil. A moderately hard tube was used at a distance of ten inches, at first three times a week, and then daily for from five to fifteen minutes, gradually increasing the length of the exposure. Care was taken that no reaction should be produced, and whenever redness or itching supervened the exposures were stopped and a cooling cream applied till the symptoms subsided. After three months' treatment the hairs fell out and the skin became inflamed. After the inflammation disappeared the sweating had also gone, and several months afterwards the improvement persisted.

3. *A serviceable cream for the treatment of acute X-ray burns*.—The writer recommends the following creamy paste for the treatment of X-ray burns:—Boric Acid, 12 drachms; Zinc Oxide, Starch, Bismuth. Subnit., and Ol. Olivæ, of each 1 ounce; Liq. Calcis and Lanoline, of each 3 ounces; Rose Water, 12 drachms. The powder should be well rubbed up in a mortar, the lanoline added; the olive oil and liq. calcis are then mixed and slowly added; when this is thoroughly mixed the rose water is added, and the whole beaten up in the mortar into a light creamy paste. This should be spread on several thicknesses of absorbent gauze and laid over the surface, and a sheet of gutta-percha tissue placed over it to prevent evaporation.

J. M. H. M.

THE BRITISH JOURNAL OF DERMATOLOGY.

NOVEMBER, 1903.

ECTHYMA TEREBRANS.

By W. ALLAN JAMIESON, M.D., F.R.C.P.E.,

Lecturer on Diseases of the Skin, University of Edinburgh; Physician for Diseases of the Skin, Edinburgh Royal Infirmary; and

LILY H. HUIE, EDINBURGH.

RAYER, between 1826 and 1835, appears to have been the first to describe correctly ecthyma, but our earliest accurate conception of the form here considered was given by Professor Isidor Neumann in his *Atlas of Skin Diseases*, published in 1885 to 1889. In plates xii and xxi he represents the whole life-history of this rare affection. The first of these shows on the back of a child a series of vesico-pustules varying from a large shot to a sixpence in size, each with a narrow red areola surrounding it. The smallest are hemispherical, but some flatten out till they appear as a vesicular ring, including a red circle, and within this a central vesico-pustule. In places there is evidence of superficial necrosis shown by blackened spots, and one has almost developed into an ulcer. On plate xxi we have represented an eruption on the abdomen and chest of a child, consisting of a number of punched-out holes varying from the size of a shot to that of a large pea. These are encircled by a vividly red, somewhat œdematous border about a quarter of an inch in breadth. In some—indeed, in most—the round excavations are so closely set that the border merges into an uniformly reddened surface studded with these perforations,

which go nearly through the skin. Their floor is a speckled grey. In places the integument had sloughed away, showing a deep red base, bearing proof of its mode of formation in the sharply cut crenated margin. In a few parts cicatrisation had occurred. The name attached is "Impetigo, Ekthyma cachecticorum." In the accompanying text, after briefly alluding to the occurrence of secondary pustular formation, Neumann points out that there is an independent variety peculiar to children.

"In them there arise isolated or closely set pustules surrounded by a red areola. These are primarily pustular, and do not become so from previous vesicles. They increase but little peripherally in size. Their localisation is in particular on the face, buttocks, loins, and extremities. The contents of the pustules dry up, and when the crusts have separated a dusky red macule remains. Should the mucous membrane of the mouth or lips be implicated, the eruption readily breaks down, is covered with a greasy exudation, and resembles aphthæ or syphilitic ulcers.

"It is not uncommon, however, to meet with a pustular eruption in anæmic, cachectic children, whose health has been lowered by some severe illness (scarlet fever, measles, variola, whooping-cough). The pustules under such circumstances have sanguineo-purulent contents, their margin is bluish red and infiltrated, and when the soft crusts are removed ulcers are disclosed, whose base is covered with broken-down exudation. Both epidermis and corium are deeply destroyed, and hence arise the punched-out losses of substance characteristic of Ecthyma or Rupia cachecticorum. Such as a rule scar over, but sometimes, if the cachexia is well pronounced, the tissues become gangrenous."

In the lower figure of plate xx of the *Saint Louis Atlas*, Hallopeau pictures an exactly similar eruption on the buttocks of a child, and remarks: "The ulcers of Ecthyma terebrans closely resemble those of soft chancres; they have the same abrupt margin, the same sanious base, the same tendency to excentric extension, the same easy spread by auto-inoculation. But their situation, the mode of onset by an erythematous papule, and the depth of the ulceration permit of a distinction being drawn."

The most complete description of Ecthyma terebrans is given by Sabouraud in *La Pratique Dermatologique*. He points out that the

primary lesion reminds one of Erythema multiforme, particularly that variety which we term Erythema or Herpes iris. The lesion in its initial stage is essentially an epidermic one, but may go on to ulceration owing to position, as when it is situated on the lower limbs, or should the disease occur in one exhausted by overwork, or in an unhealthy state. "The higher up in the body the lesions are placed, the more superficial is the disease, the more benign and curable; again, should it be located on a dependent position, should it be deep, the more malign and obstinate." Hence the ecthymatous ulcer is seldom seen except on the lower limbs, but there—in this our experience hardly coincides with his—it is very frequent. He has never seen an ecthyma of the face ulcerate, seldom even when the arms are attacked. Apart from any profound constitutional cachexia, one may fairly affirm that an almost spontaneous cure is the rule as soon as the general hygiene is brought back to what it should be.

As regards the microbe, it is a streptococcus but sparingly present in the primitive vesicle or vesico-pustule, and in scrapings from the walls of the ulcer, but it is apt to be overshadowed by the growth of more robust organisms which are implanted secondarily. It confines itself to the surface; he has not encountered it in the corium. In Impetigo contagiosa, in which, according to Sabouraud, the bacteriology is similar, he found a few very fine and oblong diplococci, which he regards as merely a stage in the development of the streptococcus. As to its botanical position, he says, "I have not discovered any difference between the cultures of this streptococcus of impetigo and those of streptococci derived from any other source. I believe in their absolute identity." This is a short *résumé* of Sabouraud's conclusions; it will be seen later how our observations differ from his.

It is noticeable that authors insist on the occurrence of this complaint in infancy and childhood. Crocker states definitely* that all the cases hitherto recorded have occurred in such. He cites, it is true, instances of multiple gangrene in adults, succeeding the exanthemata or septic poisons, but not directly impetiginous or ecthymatous.

While admittedly the ailment occurs most frequently in children, the case now to be related shows that a precisely identical and most rebellious form may manifest itself in an adult, when the conditions are comparable. In Mrs. S—'s instance, no doubt the ulceration

* *Diseases of the Skin*, 3rd edit., 1903, vol. i, p. 488.

reached its extreme intensity on the leg, but the ulcers on the back and breast, if not so large, were quite as deep and as intractable. The clinical cause in her was evidently the reduction in vitality in the tissues as a result of long-continued overwork.

CASE 1.—Mrs. S—, aged 41, Invercomrie, admitted to Ward 38, Royal Infirmary, December 29th, 1902. Wife of a manager of a sheep farm. Has eleven children, the eldest eighteen, the youngest two years. She has had all her life very hard and constant work at her home. Often rising at 5 a.m., she frequently did not go to bed till midnight, and as a consequence she felt thoroughly tired, and her appetite, from being good, failed to a great extent. She has a remarkably soft, thin, pale, and non-resisting skin. She weaned her baby in August, 1901, and the present ailment began in October of the same year. A red spot made its appearance on the left breast beneath the nipple. This became pustular in the centre, broke down, and left a gap in the integument, which extended in area until there was an ulcer three inches in diameter. This, again, gradually contracted, and is now represented by a shallow excavation. The next part affected was the centre of the back between the scapulæ, where the same red spot, followed by pustulation and then by breaking down, manifested itself. The ulcerated area here, however, assumed much larger proportions. There is now an irregular, polycyclical, ulcerated space, made up of the coalescence of a number of round ulcers, and as large as the hand. The margin is punched out and the floor of a deep red tint, with scarcely any granulations on the surface, and exuding a scanty, sero-purulent, almost gelatinous fluid. No inflammatory areola surrounds the ulcer; it is sharply differentiated from the neighbouring skin. Studded irregularly over the upper part of the back are a series of round ulcers the size of a sixpence, with a granular red floor, and discharging a yellow gummy liquid. On the left leg on the outer aspect, nearer the ankle than the knee, is a large deep ulcer, similar to those on the back, seven inches long by two broad. None of the ulcers give rise to much pain.

With the exception of a want of appetite, some constipation, and inability to walk in consequence of the large ulcer on her leg, which bled freely when the upright position was assumed, her general health could not be said to be bad. The urine was normal, the temperature

seldom rose above the natural level, she had a fair pulse, and her blood, carefully examined by Dr. Lovell Gulland, contained no organisms, nor did it vary from the standard. From time to time opportunity was afforded of studying the mode of evolution of fresh lesions. These began as a small vesicle, which soon became purulent, and on opening this a cavity in the skin, much deeper than could have been anticipated, was disclosed, from which thick pus welled freely up. Healing was always a very slow and imperfect process, whatever kind of dressing was employed.

She remained in my ward till the early part of August, 1903, when she was sent home. During all that period she was confined continuously to bed—indeed, the lower end required to be elevated by means of blocks, as unless this was done the leg became painful and bled readily. The treatment adopted to procure closure of the ulcer consisted in cleansing it with boric starch poultices; then various lotions, the application of Beiersdorf's salicylic creasote plaster muslin, to erode and stimulate the surface, iodoform, exposure to the X-rays, dressing with foil under a bandage, were tried in succession. None of these methods produced any more than mere temporary improvement. Finally, towards the end of May, the ulcer was strapped with strips of the *emplastrum saponis fuscum*, which were changed twice a day in consequence of the amount of purulent discharge which exuded. This was followed by a steady contraction in area. The ulcers on the back, *mammæ*, and other parts of the trunk were treated in much the same fashion, but the remedy which suited them best was a weak ammoniated mercury ointment, under which the greater number scarred over. Fresh pustules, however, continued to appear from time to time till the end of March, when Dr. Norman Walker took charge of my wards during my absence in Spain. He has furnished me with the following notes:

“On April 6th fifteen grains of iodide of potassium were given thrice daily. The drug was continued for a week; there was a rise of temperature while it was being administered, but no notable improvement in the disease. The leg became so septic that charcoal poultices were applied. On April 16th one drachm of levurine was ordered to be given thrice daily. Almost immediately an eruption of small pustules appeared. On close examination these were found to be so superficial that the levurine was persisted in.” It was continued till

May 25th and then given up, as no pustules had shown themselves since the beginning of the month.

When sent home on August 20th, 1903, her condition, as given in notes taken by Dr. Frederick Gardiner, was as follows:—Her health is good. The ulcer on the leg has almost healed up. One narrow streak of exuberant granulation tissue, an inch and a half long and a quarter of an inch broad, and another patch the size of a sixpence, represent the original large ulcer. Round the former margin two or three punched-out ulcers have formed afresh. The scar tissue is very thin and red. The strapping with *emplastrum saponis fuscum* to be continued.

All the ulcers on the back, including that which resulted from the subcutaneous inoculation, have healed up under the ammoniated mercury ointment, but their situation is still very evident owing to marked telangiectases in the cicatrices. One nodule the size of a pea has appeared, and several pinhead-sized pustules are discernible on close examination.

On the front of the thorax and on the abdomen all the parts have healed exactly as on the posterior aspect, with the exception of one area at the level of the umbilicus, which is still ulcerating.

In order to arrive, if possible, at some determination as to the bacteriology, and through that at the pathology of the disease, I was fortunate in obtaining the kind assistance of Miss Lily H. Huie, who threw herself heart and soul into the investigation, which was carried out in his laboratory, with the aid and supervision of Dr. Taylor Grant. The observations were commenced immediately after the patient had been for a few days in the ward, and were continued for months. Miss Huie has furnished me with the subjoined report:

A bacteriological investigation was attempted by means of—

1. Cover-glass films made from the fresh discharge.
2. Bacteriological cultures made from the discharge.
3. Inoculations with the cultures so obtained.
4. Paraffin sections of excised skin.

Details.

(In making up this statement account has only been taken of material that could be relied on as absolutely free from contamination. This meant the rejection of a good deal of preliminary work.)

1. Both small and large abscesses which had not yet burst spontaneously were opened with antiseptic precautions. Cover-glass films were made at the bedside with pus removed from the small abscesses with a sterilised platinum loop, from the large by means of a newly boiled hypodermic syringe. The films were stained by the usual methods, and also for "acid-fast" bacteria. The discharge consisted of leucocytes, mostly of the multinucleated type, and fibrin, and the majority of the film preparations showed no micro-organisms whatever. On one or two occasions they showed a diplococcus resembling in form that of gonorrhœa, but taking the aniline dyes more readily and retaining the stain by Gram's method. Films from one abscess only contained streptococcus in pairs and short chains in a fibrinous discharge from near the abscess walls. The only other organism found in the films, and which was met with on only one occasion, was a Gram-taking bacillus occurring in pairs and presenting some club-shaped "involution" forms. But it had almost certainly only occupied a hair-follicle, as traces of the sheath were present.

2. A very large number of tubes containing the usual culture media were inoculated with the purulent discharge, and incubated both aërobically and anaërobically. As the pus was very abundant in the large abscesses, it was easy to obtain syringe-fuls. A large proportion of these culture tubes remained absolutely sterile. On two occasions a whole syringe-ful of purulent fluid (equalling 4 c.c.) was drawn off and introduced into half a dozen nutrient tubes, and both times not a vestige of growth appeared. The organisms that were successfully cultured were few, viz. once a streptococcus, from the same abscess that furnished the streptococcus-containing films already mentioned; once a Gram-taking bacillus, apparently the same as the one described above as occurring in a film preparation; and there were some staphylococci once from a large abscess; but the organism of most frequent occurrence was the diplococcus already described as occurring in pus films. It was mixed with staphylococcus in the large abscess just mentioned, but on three occasions was obtained in pure cultures.

3. Inoculations were performed on the patient (her consent, after full explanation of what was to be done, having been previously obtained), by scarification, with the diplococcus and with the Gram-taking bacillus, but in both were practically ineffectual. A hypodermic inoculation was then made with the diplococcus, resulting in a

large and typical abscess, which was opened a week later; 4 c.c. of the purulent fluid drawn off proved absolutely sterile, as in the case of the spontaneous abscesses, but from scrapings of the walls cultures of the diplococcus and of *Staphylococcus albus* were obtained, and film preparations showed both organisms amongst the necrosed cells.

The patient's temperature showed no unusual vacillations after the hypodermic inoculation until the fourth day, when it rose to 99° , reached on the fifth day 100.2° , on the sixth day was 100° , and afterwards declined steadily to normal. It should be mentioned, however, that a similar sudden rise of temperature had occurred six days before the inoculation, independently of any artificial cause.

Three guinea-pigs were inoculated with the diplococcus. One developed a lump the size of a large bean, which afterwards subsided. The others remained unaffected. No subcutaneous inoculation was made with the Gram-taking bacillus, but two guinea-pigs were injected with it with negative results.

4. A portion of skin forming a young pustule was excised for sectioning. It was found that although the pustule looked quite immature it actually covered a cavity full of purulent fluid. A culture of this fluid gave rise to a pure growth of the diplococcus. Sections showed the piece of excised skin to be deep enough to include the bases of the hair-follicles, but the floor of the abscess was not comprised in the piece. Pathological changes were greatest round the part about to become the outlet of the abscess. Here the imperfectly cornified horny layer was thickened, depressed, and full of leucocytes. The transitional layers were wanting. The rete Malpighii, which was everywhere proliferating and cedematous, with many leucocytes in the lymph-channels, formed at this place two specially long processes invading the corium to its base, and enclosing between them a funnel-shaped crater occupied by leucocytes and fibrin. In this discharge no micro-organisms appeared. The cells in the processes were swollen and stained faintly. In the surrounding corium the proliferation of cells was enormous and universal. The connective-tissue cells were swollen. In some the greatly enlarged nuclei were in the act of amitotic division, but most of them already contained two or three large nuclei. There was a general infiltration of leucocytes, small round-cells, and larger cells with dense protoplasm

and a very excentrically placed nucleus, usually containing conspicuous, peripherally arranged chromatin granules—apparently the “plasma cells” of Unna. These cells were particularly characteristic in the region of the subpapillary plexus. All the blood-vessels of the corium were dilated. In parts more remote from the abscess the inflammatory infiltrations were confined to the tissues bordering the capillaries.

Many of the hair-follicles were crowded with micro-organisms, notably staphylococcus and a minute bacillus. The diplococcus appeared sometimes to be present, but was not distinguished with certainty from staphylococci.

Appended are the characters of the diplococcus with which the successful inoculation was performed, and of the Gram-taking bacillus repeatedly met with.

(A) The diplococcus grows best at 37° C. It will not grow at all at ordinary room temperature, nor anaërobically. It forms no growth on gelatine. It forms on agar, blood-agar, or serum, minute discrete semi-transparent colonies, like streptococcus; and, like streptococcus, it dies very easily. Agar cultures have a sour cheesy smell. It occurs in pairs, little clusters, and short chains. In the last the cocci re-divide in the direction coincident with the length of the chain, so that there is produced a characteristic double file of demi-cocci, making confusion with streptococcus impossible.

(B) A culture of the bacillus was sent to Dr. Král, of Prague, for identification. He recognises it as one he has often found in squames of skin, in cases of *Ulcus molle*, *Ulcus durum*, etc., and calls it a “diphtheria-like” bacillus which has never been named. It grows well on all the ordinary culture media, forming white “nail-head” colonies. It does not liquefy gelatine, but grows on it slowly at room temperature. It is non-motile. In cultures it quickly presents club-shaped involution forms.

With reference to the diplococcus, Dr. Král reports that he has frequently met with similar forms in various investigations on the human skin, and has considered them non-pathogenic.

CASE 2.—Maggie McD—, aged 21 months. Born at Slaneyburn. Father a miner. Mother has three children, the eldest five, the next three and a half. She had a stillborn child a month since. Admitted

to Ward 38, June 8th, 1903. The infant was nursed exclusively by the mother till fifteen months old. She then was an active, healthy child, running about. From that time till now she has had everything that the other members of the family have at meals—bacon and eggs, meat, vegetables, and much tea. Her health has gone back, and she is now an extremely pale, weakly child, thin, flabby, and peevish.

Her present disease began with an abscess on the left arm in November, 1902, and shortly after extended to the legs. Since then fresh eruptions have continuously come out. The scalp is studded over with crusts exactly resembling those of *Impetigo contagiosa*, pale yellow, crumbly, and “stuck on.” On the face are a number of flat vesicles; these are depressed in the centre, but have a narrow vesicular margin, with no, or very little, areola. There are also some larger vesico-pustules, but none are the diameter of a small pea. On the left cheek and on the ear are punched-out ulcers, half an inch across, with a narrow, red, slightly œdematous areola, and beyond this a fine collarette of epidermic scales. The back and chest are practically free from lesions of any kind. On the thighs, especially on their inner aspect but also on the outer, are many closely set flat vesicles, like those on the face, but in general smaller, since sundry of these are not as large as a pin’s head. Though individually the colour of the skin in appearance, a cluster has a brownish-red tint. There are also in this situation punched-out ulcers with narrow cushion-like border, and either a yellowish floor, or with a black crust in their centre. On the legs, particularly on the inner side and on the calves, are numerous separate depressed scars, left by ulcers which have healed. Some of these are purplish in colour; none are quite white. On the dorsum of each foot is a deeply punched-out ulcer with a bluish-white areola. The limbs are very cold and the temperature always subnormal. On the right side of the neck an abscess the size of an egg had formed; this burst while Miss Huie and I were examining it; specimens of the pus were at once secured and placed in tubes for cultivation, and the walls were scraped and the scrapings inoculated on tubes. The surface of the abscess had been washed with soap and water, with carbolic acid solution, and with alcohol, and just when this procedure had been completed, and we were about to empty it with a sterilised syringe, it burst.

On June 12th two small flat pustules on the thigh were carefully

cleansed with carbolic lotion and alcohol, then opened with antiseptic precautions. The pus, as well as scrapings from the walls, were inoculated into tubes by Miss Huie, and films made.

During her stay in the infirmary till her discharge well on August 1st, the local treatment consisted in the constant application of a five-grain to the ounce ointment of ammoniated mercury. With this the appearance of fresh pustules steadily lessened, and latterly ceased entirely. Only pale purplish thin scars remained where the pustules had been. These were numerous on the legs and thighs, but very few on the face. The scalp was perfectly healthy, merely red points showing where the pustules had been; the hair had grown well. Her general health was excellent; she was plump and active, and had wholly lost the peevishness so marked on admission. The abscess had closed, though a small amount of serum still oozed at times from the surface, and a degree of hardness persisted. The only peculiar feature was the temperature. For some days after her admission it was normal, but then it rose rapidly, and in the course of three days had reached 102.5° ; and till July 17th it continued to be most irregular, a day or two normal or subnormal, then for several days oscillating between 101° or 102° and 97° . No reason for this was discovered. She took small doses of Easton's syrup all the time she was in the ward. Directions were given to keep the skin clean and to dust with a ten per cent. boracic and talc powder.

Miss Huie also conducted an investigation into this case, and has reported as follows :

"A bacteriological examination was made on the same lines as in the previous one, except that no inoculations were performed and no skin was excised.

"Details.

"1. A very large abscess on the neck was opened with most strict antiseptic precautions. A number of film preparations made at the bedside were stained for tubercle and in the ordinary ways. They are all rich in streptococcus, but no other microbes could be detected. The walls of the abscess were gently scraped, and two agar tubes inoculated with the scrapings. There resulted growths of streptococcus, *Staphylococcus pyogenes* (?) *albus*, *Staphylococcus aureus*, and one small culture of a diplococcus indistinguishable from that met with in

Mrs. S—'s case, mingled with a bacillus, arranged in pairs, which died out before it could be cultured and identified.

"2. On another occasion two very typical abscesses on the legs were opened. Pus films showed here and there a few very short streptococcus chains, and no other organism. Scrapings from the walls of both abscesses gave rise to magnificent pure cultures of streptococcus, and to no other cultures whatever.

"3. Later on two small, very young pustules were opened. At this stage they were merely slightly raised, reddened, vesicular swellings, and contained no pus. A little blood was obtained, and in one film a little clump of bacilli in pairs was seen, probably the contents of a ruptured hair-follicle. No cultures appeared in the inoculated tubes."

Miss Huie adds, "I find by culture experiments that the presence of other cocci is an immense stimulus to the growth of streptococcus. I think now that the prevalence of streptococci in some abscesses of ecthyma is only due to a secondary infection, although it is very misleading. Still the conclusion to be drawn from our investigation on Mrs. S—'s case is that streptococcus is not the causative organism."

Sabouraud regards the diplococci which he found in impetigo as the rudimentary form of the streptococcus. While too much must not be made of the one subcutaneous injection which we made, yet the resulting abscess and ulcer which succeeded it were absolutely identical with those abscesses which formed spontaneously and the ulcers which ensued. It may be objected that there were no inoculations into other individuals as control experiments, but such would have been unjustifiable; and, indeed, it is more than doubtful if such would have been successful, since a special soil appears to be requisite for the sequence of the phenomena.

The close relationship of the diplococcus to the disease is shown by its invariable occurrence in the walls of the abscesses, though it would be too confident an assertion to make that it is the sole cause. While it is true that the same toxin may, as in syphilitic gummata, occasion in one person deep and ulcerative lesions, and in another superficial ones with little or no destructive effect, still it seems difficult to explain why, if a streptococcus is the cause, the identical organism should in one individual produce erysipelas, in another Impetigo contagiosa, in a third Ecthyma terebrans, and that each form

of ailment should, so to speak, breed true, without any alteration or intermixture. It does not yet appear that this can be fully accounted for on the theory of symbiosis, and difference of soil cannot be solely the cause, as in a school with any amount of such varieties of soil, *Impetigo contagiosa* is reproduced in the case of every boy attacked, while epidemics of erysipelas do not arise. Till more fully elucidated, for this peculiar complaint under consideration the term *Ecthyma terebrans* is appropriate.

CASE OF PITYRIASIS RUBRA PILARIS (DEVERGIE) IN CHILD OF FOUR YEARS.

By ARTHUR HALL, M.A., M.B.CANTAB., M.R.C.P.,

Physician, Sheffield Royal Hospital; Professor of Pathology, University College, Sheffield.

R. O—, a Jewess, aged 4½ years, was seen in consultation with Mr. C. R. Dearden (of Sheffield) on January 29th, 1903.

History.—She had been perfectly well up to three weeks ago, when the rash appeared on the trunk. It has gradually spread over the head, body, and limbs. It is irritable, and the child is beginning to get “run down.” There was no history of any previous illnesses, nor had any member of the family suffered from skin disease. As she could not be properly attended to at her own home, she was admitted into hospital on January 30th.

Present condition.—The scalp is covered with fine, powdery, white or yellowish-white scales. There is no evident loss of hair; some thickening of the skin, which feels tense.

Face, neck, and ears.—The skin is uniformly red and wrinkled; it is more or less thickly covered with white or yellow-white scales. About the eyes and on the cheeks and chin the scales are fewer and have the appearance of an ichthyosis, whilst over the ears, neck, and forehead they are fine and powdery.

Arms.—From the shoulders down to the finger-tips, except for small areas in the neighbourhood of the elbows, they are completely covered by a red papular eruption which feels rough to the touch. In the lower forearms and over the dorsa of the hands the individual papules

have run together to form a continuous erythematous sheet, in which they can be seen closely packed together, and giving the same rough sensation to touch. The hands are swollen, and on the palms and the digits there is profuse irregular exfoliation. The dorsa of the fore-arms are covered with small silvery scales arising from the component papules.

Trunk.—Both back and front are covered with eruption; this is more or less in a continuous sheet on the upper chest, back, and nates, whilst on the abdomen the papules are discrete, and are seen here and on the thighs in their most characteristic form. They have a distinctly linear arrangement, especially around the umbilicus, where they form concentric curved lines. They give the sensation of rubbing a nutmeg-grater.

Legs.—They are fairly thickly arranged on the thighs, less so on the legs, and are discrete except over the fronts of the knees, soles of the feet, and toes; in the latter places there is a similar brilliant red erythema with exfoliation as on the hands.

There are a few discrete papules on the dorsa of the feet.

Characters of eruption.—According to the part of the body examined, three different appearances of the eruption may be distinguished:

(a) On the abdomen and lower limbs discrete papules, more or less circular in outline, bright red, tops rounded, but forming a distinct surface, diameter varying from 2·5 mm. to 1 mm. or less. The largest papules are on the abdomen, whilst those on the legs are smaller. Interspersed between the large papules on the abdomen are here and there extremely small ones. On the legs the papules are in some parts acuminate. Hairs appear in the centres of many of the papules, but this is not universally the case. Some have caps of silvery scales. Where the papules are not too closely packed their arrangement in lines is very distinct; especially is this so around the umbilicus, where a concentric arrangement is very clearly shown.

(b) On the chest, back, buttocks, and arms the papules have become confluent so as to form a continuous sheet, bright red, rough to the touch, more or less covered with scales, and still showing its original formation from individual papules by its division into small angular areas corresponding to them.

(c) On the scalp, face, ears, hands, and feet (soles and toes) there

is a diffuse exfoliating erythema, in which no evidence of a papular character is observed, merely a bright red skin more or less hidden with silvery scales, varying in size from large flakes to powdery dust. And it will be noticed that whilst in the arms there is more or less gradation from papular to erythematous areas, in the foot the neighbourhood of the sole is comparatively free, whilst the sole and heel to the top of the tendo Achillis is severely affected.

General condition.—Nothing was observed on the mucous membranes anywhere, nor was there any evidence of visceral disease. The child took its food fairly well, slept fairly. There was no marked wasting. The itching was considerable at first. The temperature was above normal for the first five days after admission, being between 99° and 101°. After that it was usually normal.

Progress.—The patient was put on to Liquor Arsenicalis mj three times a day.

February 2nd.—Very drowsy all yesterday; would not take her food or speak. The abdominal papules running together. Each is losing its rounded top, becoming flattened and angular in outline, and showing a fine scaly margin; *i.e.* the skin around each papule shows a free scaly edge as though the papule had burst through it. The continuous confluent sheets on the abdomen are due to enlargement of individual papules and their coalescence.

3rd.—The eyes appear very sore and watery, the margin of the lids being inflamed and slightly everted. Some crusts at the inner angle of the right eye. Around the mouth the skin is quite clear.

4th.—The papules on the abdomen have coalesced still further, as also those on the thigh. On the legs they are still discrete. The scaling is more profuse, the back being now one continuous silvery surface. The skin of the hands and feet is more supple, and the scales are less adherent. Around the mouth and eyes the scaliness is distinctly disappearing. The skin about the shoulders, arms, and axillæ shows coarse folds.

11th.—Liquor Arsenicalis was increased to mij t. d. s. The hair was cut short. An ointment consisting of salicylic acid 5 per cent. in diachylon ointment was applied to the left arm and leg. The child is very bright and well, and the irritation much less. On the forearms and forehead the scales are much thicker and closer. The inflammation of the abdomen is much less, and the eruption is receding from

the mouth. The hands and feet are distinctly less red and scaly. There are no discrete papules now except on the legs.

18th.—Very much better. The ointment has been applied all over, and occasional alkaline baths have been given. The coarse scaling of the hands has almost disappeared, and the scales on the back are much less. The face is much clearer.

20th.—Still thick scales on the head. Blood-count shows no leucocytosis or abnormal relative proportion of the different leucocytes.

23rd.—Slight tonsillitis.

March 6th.—Arsenic stopped.

18th.—Skin quite clear.

The patient was seen on August 20th; she was in excellent health, and had not had the least recurrence of the eruption.

This case presents in a typical form the features to which various names have been given in the past, and concerning the identity of which there has been in the past much confusion. Of the names which it has received it seems to me that the one given to it by Devergie is on the whole the more satisfactory, and is less likely to lead to confusion than that of *Lichen acuminatus*. Each name, however, lacks something, and the picture which each presents will be more or less brought out in a particular case according to the stage in which it is when seen.

I had the opportunity of watching this case carefully day by day during its progress, but unfortunately did not see it until it had reached almost full development, and am therefore unable to give any details as to its early stages. The points of interest seem to be—

1. The age of the child, the youngest case recorded being 2½ years old.

2. The comparatively slight constitutional symptoms even when the eruption was fully developed. For a few days she seemed apathetic, and there was some pyrexia, but on the whole the general condition was distinctly good.

3. The intensity of the exfoliative dermatitis of the palms and soles. On the latter it is interesting to note how even when the eruption was at its height the skin beyond the soles was comparatively clear, so that the sole and the adjacent skin over the heel and up to the tendo Achillis appeared to be picked out by the eruption. This is well seen in the illustration.

4. The absence of any horny plugs in the papules, together with the absence of dark papules on the backs of the fingers, is possibly due to the child's age and the consequently immature state of the skin.

5. Whilst hairs could be distinctly seen in the centre of many of the papules, this was not true of all.

6. The gradual increase in area of the individual papules associated with a flattening of their tops and loss of their circular outline. Each seemed to lose its individuality.

As regards treatment, the very small doses of arsenic can hardly have been sufficient to influence the disease markedly, and the improvement was probably rather owing to unknown factors than to internal medication. At least it seemed to do no harm. Local treatment consisted of the application of 5 per cent. salicylic acid in diachylon ointment, which was suggested to me by Dr. Brooke (of Manchester), to whom I showed the case whilst in hospital. It certainly proved beneficial. The child was also given alkaline baths daily, prior to the application of the ointment, and these not only seemed grateful to her, but helped considerably in removing the scales.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of this Society was held on Wednesday, October 14th, 1903, Dr. H. RADCLIFFE-CROCKER in the chair.

The following cases and specimens were shown :

Dr. S. E. DORE showed (1) a middle-aged woman with large, very definitely circumscribed patches of hyperæmic and slightly scaling skin on the legs, thighs, and arms. The eruption consisted of patches varying in diameter from two to four inches, the shape was almost circular or oval, the scaling was slight, infiltration absent, and the surface perfectly dry. The disease did not seem to be made up of agglomerations of small papules, but rather by the peripheral extension of the smaller lesions. It had been present for ten months and

had proved very resistant to treatment. There was a history of marked dyspepsia on inquiry.

Dr. RADCLIFFE-CROCKER said that this was the type of eruption which he labelled as *Eczema circumscriptum* for his own private convenience, and that he had found painting the patches with strong solution of ichthyol of service.

Mr. WILLMOTT EVANS said that he had found that the painting of the patch with strong iodine solution was generally followed by its disappearance.

Dr. WHITFIELD said that he was in the habit of noting the eruption down as discoid eczema for the purpose of reference, and that he had found the solution of iodine in oleic acid and liquid paraffin similar to that sold under the name of valsol and vasogen of service. He thought it was undoubtedly one of the class differentiated by Brocq under the name of parapsoriasis, but he saw no advantage in the name.

(2) A case of typical *v. Recklinghausen's disease* in a Russian, further details of which will be reported later.

Mr. WILLMOTT EVANS showed a case of *Ichthyosis linearis*. The patient was a boy aged 9 years, and according to his mother's account showed no sign of the disease till the age of two years. On the dorsum of the left hand was a rough, raised, dark streak, running near the inner border; at the roots of the fingers it divided and ran along the dorsal aspect of the ring and little fingers. These lines corresponded, therefore, to the distribution of the dorsal branch of the ulnar nerve. The dorsum of the first phalanx of the middle finger was also slightly affected, and this frequently receives a branch from the ulnar nerve. The raised lines were rough and verrucose in character. There were no subjective symptoms.

Dr. GRAHAM LITTLE showed (1) a case of *tertiary syphilis* in a woman aged 45. The case was peculiar in many ways. The patient had never been married, and had never had any eruption on the body before the appearance of the present disease. This had commenced twelve or thirteen months ago with an ulcer on the right foot on its dorsal surface. This spread peripherally, and other ulcers formed round it. At the present time she has an area about three inches wide and four inches long (the long axis being in the long axis of the foot), upon which are arranged in a roughly circular manner eight ulcerated elevations from half an inch to an inch in diameter, and raised from a quarter to a third of an inch above the surface of the skin. These

elevations are closely juxtaposed but discrete, and they form the periphery of the circinate figure above described; in the centre of the figure there are some smaller nodules, and the skin is infiltrated and red, but the infiltration is not comparable to that of a tubercular sore. The summits of the elevations are uniformly ulcerative and covered with unhealthy sloughs; on scraping with the sharp spoon the tissues were necrotic to a considerable depth, the ulcers being deeply undermined.

The clinical appearance of the foot strongly suggested the diagnosis of blastomycosis; but on the thigh there were two smaller ulcers hardly at all raised, and with a serpiginous outline exceedingly suggestive of syphilis. These had appeared within the last six months, and upon further questioning the patient owned to having had a sore tongue, and some trace of scarring was visible on this organ.

A smear preparation was made from the *débris* removed with the sharp spoon from one of the elevations on the foot, and stained for micro-organisms. A long bacillus was present in great numbers, especially in the deeper parts of the scraping. Only a few cocci were seen as compared with the enormous preponderance of the bacillus, which did not stain with Ziehl-Neelsen's stain.

One of the nodules from the centre of the area on the foot was excised, and examined histologically. The section showed a deep infiltration with cells, which appeared to be mononuclear leucocytes, no plasma-cells being found. The epidermis was intact, but immediately beneath it there were several small miliary abscesses, and the cells in the neighbourhood were destroyed. In one section in one of these miliary abscesses, two long bacilli exactly like those seen in the smear were found.

(2) A case of *Dermatitis herpetiformis* in a female child aged 3 years. She had been for the past three months under the treatment of a competent medical practitioner, but without much improvement resulting. When first seen she had groups of clear vesicles on a red base, distributed principally on the thighs and legs, and especially round the vulva, the labia and *mons veneris* being covered with vesicles and scabs. On the face there were numerous small vesicles and pustules which appeared exactly like the lesions of *Impetigo contagiosa*, but they did not improve with treatment. On the thighs and legs the lesions seemed auto-infective, as the parts of the leg in

apposition with the thigh, when this was completely flexed, were secondarily covered with lesions apparently derived from contact with the vesicles on the thigh. Cultures in fluid media were taken on two occasions from a large clear vesicle on the thigh forming one of such a group, and on each occasion a pure culture of streptococcus was obtained.

(3) A case of circumscribed *eczema* on the thigh of a woman aged 35. This had commenced as a small dry patch, which had slowly enlarged to cover an area of about seven by five inches. There were no other parts of the body affected. The affection had lasted nine months, and had resisted all kinds of treatment. The case was brought up to elicit opinions on a type of *eczema* which was commoner in children than in adults, and which did not seem to fall within the limits of seborrhoic *eczema*. It was perhaps to be included in the class of chronic scaly dermatitis which Brocq had recently named *parapsoriasis*.

Dr. MACKAY (introduced) showed a woman aged 48 years, with a circumscribed eruption on the arms and thighs. The patches had begun two years ago with a cessation of the menses, and consisted of red circular areas with a fairly defined margin, not infiltrated, irregular in shape, and carrying only the finest possible scale. The scalp was free, but the face was distinctly hyperæmic, and there was a marked tendency to flushing, and some of the capillaries were dilated. There was distinct atonic dyspepsia present, and some neurotic element. Treatment had not modified the eruption in the least, though the following drugs had been tried :—Cuticura remedies on the patient's own account, Mouilla soap, boric acid, resorcin, sulphur and salicylic acid, Unguentum Hydrargyri Ammoniati, boro-benphene (Heil), adrenalin locally, ichthyol soap externally and tabloids internally, protargol in 3 per cent. solution, also bismuth and perchloride of mercury with camphor and spirit, and glycerole of lead.

Mr. MALCOLM MORRIS showed (1) a man aged 53 years, who had suffered from *Lupus erythematosus* of greater or less severity since the age of twenty-six. About eight months ago a fresh acute outbreak had taken place, and he had been affected at the same time with severe intestinal pain, though there was no hæmorrhage either from the

stomach or bowel. When shown he exhibited characteristic patches of the eruption on the face, scalp, and hands, but the interest of the case lay in the extremely severe affection of the mucous membrane of the mouth and tongue. The tongue was of the most extraordinarily vivid red colour, the surface was smooth and shining as if the whole of the tongue had been denuded of the superficial epithelium, and the papillæ were almost if not quite absent. There was nothing to indicate that the condition was due to *Lupus erythematosus* except its association with the spread of the eruption in other parts; and the exhibitor commented on this, and expressed the opinion that in this case the condition of the mouth would have been absolutely impossible to diagnose without the aid of the cutaneous eruption.

(2) A woman aged 30 years, in whom an eruption of *Lupus erythematosus* had begun on the scalp eight years ago. Recently she had had some general malaise, and the eruption had spread vigorously. When shown she had a great deal of characteristic eruption on the face and head, and there were also numerous typical atrophic patches on both fore and upper arms, some being almost as large as the palm of the hand. Her tongue and palate were also involved, and in this case the lesions on the tongue exactly resembled those on the skin, being represented by small circular atrophic patches of smooth pearly scar surrounded by an edge of vivid hyperæmia.

Dr. SEQUEIRA showed (1) a girl aged 15 with numerous *leg-ulcers*. Although never in robust health, the patient was well until June, 1902, when a crop of "blind boils" appeared upon the legs. These broke down into ulcers, which healed up under local treatment (lotions and fomentations). In June, 1903, a fresh crop of "blind boils" appeared upon the legs, and these rapidly broke down into ulcers. The patient came up to the London Hospital, and was seen first by Mr. Barnard, by whose courtesy the case was presented at the meeting. The patient is anæmic, but there is no evidence of visceral disease. The ulcers are irregular in outline, and vary in size from a shilling to a five-shilling piece. Three are situated on the outer side of the right leg in its upper third, and there is a large, very irregular ulcer on the inner aspect of the right calf, just below the belly of the gastrocnemius. On the left leg there is a small ulcer just below the head of the fibula, and one near the middle of the outer aspect of the

leg, and a third over the upper part of the gastrocnemius posteriorly. A very deep ulcer extends across the front of the ankle, and in this the extensor tendons are exposed. The edges of the ulcers are slightly raised, and clean-cut, and undermined. A probe can be passed under the edge all round. The bases were dirty, but fomentations have rapidly cleaned them up. With the exception of the ulcer in front of the left ankle there is no attachment to deep structures. On the left thigh there is a small indurated patch, which shows no signs of breaking down. It does not in any way resemble the early stage of Bazin's disease, but rather a pigmented chronic lupus patch. There are numerous pigmented scars on the sites of the ulcers which developed a year ago. There is no sign of congenital syphilis, and no history or evidence of tuberculosis. The ulcers are painful, but there is no alteration of sensation in either leg. Sensibility to touch, pain, heat, and cold are unimpaired. The case was shown for diagnosis.

Opinions rather favoured the view that the lesions were tuberculous, though of an unusually rapid type. Some members, however, were of opinion that the condition might be artificial, a supposition which can easily be cleared up, as Dr. Sequeira has admitted the patient into the London Hospital. Congenital syphilis was also considered, but the majority of members did not favour the view.

(2) A woman of 50, with an indurated patch on the left calf, involving skin and subcutaneous tissue. The patient had been the subject of Phlegmasia alba dolens, and the condition was considered a sequel of that disease.

Mr. ARTHUR SHILLITOE showed a young man aged 19, in order to demonstrate the effect of copaiba in the treatment of *psoriasis*.

The patient had always enjoyed good health, and the only point of interest in the family history was the fact that an elder brother, now aged 27, was some eight years ago affected in a similar manner. In the present case the disease commenced last May, and when seen on August 24th the patient was found to be covered on the abdomen, back, and extensor surfaces of the extremities with a psoriasis of the annular type. He was given copaiba, but no external treatment. The eruption has very considerably cleared up, its previous extensive distribution being seen in the now fading pigmentation left on the extensor surfaces of the extremities, etc.

Dr. WHITFIELD showed a man aged 35 years, with a good example of *Acne keloid* on his neck. The history was that he had had syphilis five years previously, for which he was treated at the Lock Hospital. Owing to efficient early treatment he had had no early rash, and had had no eruption on his skin until a twelvemonth ago, when spots came out on the back of his head and also on his neck. These had healed up and broken out again and again round the lower part of his neck, but on the hairy margin at the back of his neck they had developed into growths. When exhibited it was to be seen that he had a line of somewhat exuberant serpiginous cutaneous gummata on the front of his neck, extending from immediately behind the angle of his jaw downwards and forwards to the sternal notch. These represented the still active edge of what must have been a formidable eruption, since behind this line, right round to the back of the neck, in a band of five inches in width, the skin was entirely converted into an irregular, and in places almost bridled scar. At the margin of the hair in the middle line, and a little to the right behind, there were two oval patches about half an inch in width by about one inch in length, of smooth, shining, raised scar, the elevation being a full quarter of an inch above the surrounding level. In the centre these patches were quite denuded of hair, and looked like ordinary keloid, but at the edge the hair could be seen to be drawn together in tufts like little camel's-hair pencils. When first seen there were two or three deep-seated, indolent-looking pustules round the hair-follicles of the central patch, but these had apparently disappeared at the time of exhibition. Dr. Whitfield said that he thought the case was especially interesting, beyond the fact of the disease being always rare, from the fact that the growths and the syphilitic eruption apparently dated from the same time. In view of the strife that was at one time current as to whether *Acne keloid* was syphilitic or not, this case might certainly be used as an argument for its syphilitic origin. The exhibitor, however, expressed his opinion that this particular change was not syphilitic, with which all the members present seemed to agree.

CURRENT LITERATURE.

ON TRICHO-HYALIN. HANS VÖRNER. (*Dermat. Zeitschr.*, Bd. x, Heft 4, p. 357, August, 1903.)

By means of various stains and the use of alkalies, acids, and digestive fluids, the author comes to the following conclusions:—The cells following those of the hair-matrix are not regular, typical prickle-cells. The fibrillæ of the cells of the hair-cortex differ from those of ordinary prickle-cells sufficiently to render it necessary to look upon them as at any rate modified.

No fibrillæ are to be found in the centre of Huxley's sheath, and in the cells of the two limiting cuticles there are no fibrillæ to be found, though they may be observed in Henle's sheath. The cells of the hair and the sheaths flatten in the opposite direction to that of the ordinary epidermic cells. In many of the sheaths—in the hair-medulla, Huxley's, Henle's sheaths, for example—the cells do not lose in size before they keratinise; on the contrary, in the medulla and in Huxley's sheath they even enlarge. In the rete Malpighii one usually finds a regular proportion between the thickness of the granular layer and that of the cells beneath, but this relation does not exist with any regularity as regards the hair. The granules present in the hair and its sheaths are not as they have hitherto been thought to be—eleidin or kerato-hyalin.

In order to fall into line with Waldeyer's name of kerato-hyalin, Vörner suggests the name tricho-hyalin for the substance forming these granules, but expressly states that he does not offer the name from any belief that it is identical with or related to hyalin. Unlike kerato-hyalin, tricho-hyalin is not always in the same form, giving the impression that it is a more or less solid substance; on the contrary, where it occurs it appears to derive its form rather from its relations to the nucleus and protoplasm, and it therefore appears to be, if not fluid, on the borderland between solid and fluid. On the outer skin the relationship between eleidin and kerato-hyalin is roughly one third, whereas in Huxley's sheath it is about one to fifty, and in the medulla and Henle's sheath the tricho-hyalin occurs without any eleidin at all. The origin of tricho-hyalin is not difficult to determine; it commences in the form of fine granules in the protoplasm of the cells, and has no relationship to the nucleus or fibrillæ. Lastly, it appears earlier in the development of the skin than kerato-hyalin, being found in the primary hairs.

A. W.

CLINICAL NOTES ON NAIL DISEASES. II. ECZEMA STRIATUM MEDIANUM UNGUIUM. By JULIUS HELLER. (*Dermat. Zeitschr.*, Bd. x, Heft 4, p. 346.)

THE case reported was that of a woman aged 36 years, who stated that she was "nervous," but showed no signs of neurasthenia. She had no special hard work to perform, but had occasionally to dress the leg of her father, who was suffering from senile gangrene of the foot. The disease had existed for three years, and as the patient could give no description of its onset, probably began insidiously. The digits affected were the left thumb, the left index and middle fingers, and the right thumb. All four nails showed a slight grooving running from the posterior

fold to the free margin of the nail-plate. Across this groove were some transverse grooves from two to four millimetres in length, and of about half a millimetre's depth. The longitudinal groove lay directly in the middle of each nail, and gave the impression that a hard substance had been drawn along the nail so as to cause a depression. The nails were, however, of normal hardness, and there was no question of the appearances being due to artefact. No other symptoms were present anywhere, and there was no sign of inflammation. The treatment adopted was the administration of arsenic internally, and the local use of equal parts of oil of cade and linseed oil after soaking the hands in a warm bath. The result was a recovery in four months. By calculating the measurements of the nail it was found that the morbid process must have stopped almost immediately the treatment was begun. Heller says that he classifies the case as eczema on account, first, of the fact that such abnormalities are seen when eczema of other parts spreads to the matrix, and secondly, of the result of anti-eczematous treatment.

A. W.

NOTES ON THE PROTOZOA-LIKE PARASITES IN SYPHILIS. By
MAX SCHÜLLER. (*Dermat. Zeitschr.*, Bd. x, Heft 4, p. 333.)

THIS paper deals at some length with the appearances found by Max Schüller in syphilitic lesions, chiefly primary sores, and is a sequel to a paper published by him in the *Centralblatt für Bakteriologie* (Bd. xxii, Originale 5—9).

In this paper he describes the brood capsules, the large and small parasites, and empty capsules, and as the result of one culture the presence of spermatozoon-like bodies. Culture seems to have been successful in several cases, and was carried out on a medium to which fresh sterile blood was added. Apparently all forms of the organism are movable, and there are numerous drawings of it in various stages and motile forms. For details it is necessary to refer to the original paper, as it does not lend itself well to abstracting.

A. W.

ON LICHEN SCROFULOSORUM. FRITZ PORGES. (*Archiv f. Dermat. u. Syph.*, August, 1903, lxvi, p. 401.)

THE question whether Lichen scrofulosorum is a tubercular disease (due to the local presence of tubercle bacilli), or belongs to the group of the tuberculides and is the result of the action of the toxin of the tubercle bacillus, is still the subject of controversy. In this connection the following two cases reported by Porges are of interest.

Case 1 was a typical example of Lichen scrofulosorum occurring in a tubercular subject. The patient was seventeen years of age, had a delicate constitution, well-marked scrofulous glands, and the characteristic exanthem of Lichen scrofulosorum on the skin of the trunk. A microscopical examination of several lesions showed no definite changes in the epidermis, but tubercular foci in the corium, consisting of "round-cells, epithelioid cells, and giant-cells." There was a cellular infiltration around the sweat-ducts, and a perivascular inflammation of the vessels of the corium.

Case 2 was an example of an eruption resembling Lichen scrofulosorum which followed a series of injections of "new tuberculin" in a patient suffering from Lupus vulgaris. The patient was aged 19, and presented a patch of Lupus tumidus

on the nose, with destruction of the alæ nasi. He was treated with daily injections of 5 mg. of the "new tuberculin." After four injections there was a rise in temperature and a severe local reaction on the nose, and an exanthem simulating Lichen scrofulosorum appeared on the skin of the trunk. A histological examination of a piece of the affected skin of the trunk showed inflammatory changes around the blood-vessels, hair-follicles, and sweat-glands, but no suggestion of a tubercular architecture.

The writer regards Case 1 as a true example of Lichen scrofulosorum, but believes that Case 2 is not so, but simply the result of the tubercular toxin. He considers that a true Lichen scrofulosorum should present a tubercular histology.

(From this paper it would seem that the writer holds the view that Lichen scrofulosorum is a true tubercular manifestation, a view held also by Jacobi, Neisser, Riehl, and other well-known observers. He admits, however, that an exanthem resembling it clinically may be produced by the circulation of tuberculin, but that in the latter case the histology is not that associated with tuberculosis. Similar cases to the second one reported by Porges have been described by Rona, Schwenninger, and Buzzi, but these writers seemed to believe that the exanthem resulted from the calling forth of a latent Lichen scrofulosorum by the tuberculin. It is of greater importance to demonstrate the presence of the tubercle bacillus than that of a tubercular architecture; still it is more convincing to find the latter than neither, and the two cases here reported merit very careful reflection.)

J. M. H. M.

ON A CIRCUMSCRIBED DEFECT (APLASIA) OF THE CUTIS AND SUBCUTIS. HANS VÖRNER. (*Archiv f. Dermat. u. Syph.*, August, 1903, lxvi, p. 407.)

THE defective skin referred to by the writer consisted of two bald patches situated on the scalp of a dark-haired boy of four years of age. They were noticed at birth. In shape they were circular, one being 25 mm. in diameter and the other 15 mm. They were situated close together on the vertex of the scalp, being separated by a narrow hairy strip about 2 mm. in breadth. The bald patches were depressed, smooth, and glossy, and presented no follicular openings. To the touch they felt as soft as the surrounding healthy scalp. A histological examination of one of them showed that the epidermis was attenuated, and that the basal layer formed a straight line in the sections owing to the complete absence of the papillary ridges. The stratum corneum was present, and was almost as thick as the rest of the epidermis, which consisted of four or five rows of prickle-cells, flattened so that their long axes and their nuclei tended to be arranged horizontally. The fibrous elements of the corium seemed normal, but their distribution, as well as that of the blood-capillaries, had a marked tendency to be horizontal instead of forming an irregular network. Hair-follicles, sebaceous glands, and sweat-glands were absent from the corium, and there was also a complete disappearance of the subcutaneous fat. There was no history of a similar defect in any other member of the family.

Cases closely resembling this one have been described by Priestley, Hans v. Hebra, Hoffmann, and others.

J. M. H. M.

**CONTRIBUTION TO THE KNOWLEDGE OF ALOPECIA CON-
GENITA FAMILIARIS.** ALFRED KRAUS. (*Archiv f. Dermat. u. Syph.*,
August, 1903, lxvi, p. 368. One plate.)

By "Alopecia congenita familiaris" the writer means a congenital absence of hair occurring in several members of a family. A brother and sister, aged respectively $1\frac{1}{2}$ and $3\frac{1}{2}$ years, are the subjects of this contribution. They were both born with hair on the scalp, but this began to fall out at seven weeks of age in the case of the boy, and at five weeks in that of the girl. The hair in both became gradually thinner until, in a few weeks, their scalps became perfectly bald. When they were examined their scalps were smooth, atrophic, and glossy, and there were no follicular openings visible. Inflammatory changes were absent. In the girl the lanugo hair was absent in the breast and extremities, and the cilia were deficient in the lower eyelids; in the boy there was no lanugo hair on the body, and the cilia were absent from the lower eyelids. The nails were not affected in either case. The mother gave a history of another boy in the family whose hair had come out at four weeks, and a fourth case in the family was also mentioned. The last two cases are not fully reported by the writer.

A histological examination of pieces of the scalp from the first two cases showed the remains of the original lanugo hair of the scalp in the form of shrunken hair-follicles, in which the papillæ were absent and the inner root sheaths, as well as the hairs, had disappeared. In some cases the follicles had become transformed into cysts connected with the sebaceous glands. The parents of the children were healthy and had normal hair, and no history of a similar occurrence in any of the antecedents of the family was obtained.

From the clinical appearances and history, as well as the histological changes, the writer concludes that the condition is the result of an interference with the normal hair-change which should begin *in utero*. The lanugo hair had been present, but, instead of becoming replaced on the scalp by the permanent hairs shortly after birth, the lanugo-follicles had undergone a regressive change, and no permanent hairs had developed.

A number of these anomalous cases of so-called "congenital alopecia" have been reported from time to time. Bonnet collected a large number of them in man and animals, in a paper entitled "Über Hypotrichosis congenita universalis." The majority of these cases, where children were born with no hair on the scalp, were examples of delayed hair-change, and the permanent hair had not yet erupted. In a number of cases which have been reported the nails have also been absent or defective. In the cases described here by Kraus it is interesting also to note that there was no evidence of disease of the scalp, such as ichthyosis or Lichen pilaris, to account for the condition.

J. M. H. M.

ON PALMAR KERATOMA AND ITS TREATMENT. ARNOLD SACK.
(*Wien. klin. Rundschau*, October 4th, pp. 721—723.)

ANALYSIS of the underlying processes which give rise to keratomata shows, so far as can be recognised histologically, anomaly of formation of the horny layer. According to the views of Auspitz and Unna, the latter of whom took a more extended idea of the group of parakeratoses, and included under this designation considerably more than psoriasis and lichen, to which Auspitz had confined the

term, palmar keratomata must be included under the parakeratoses; and they must be included under those parakeratoses in which the horny formation is not slower, but more rapid than usual. To the eye, the most noticeable sign of this affection, which must, histologically, be defined as parakeratosis, is the increased coherence of the horny layers brought about by the excessive moisture of the horny substance overlying the epithelium. It must be remembered that the regions most affected by keratomata are the palmar and plantar surfaces, areas in which the follicular and sebaceous glands are entirely wanting, while the coil glands are exceptionally well developed. Observation, moreover, shows that patients suffering with keratomata are troubled with concomitant hyperidrosis of the palm of the hand and of the fingers, so far as these areas have not been affected with the disease. On the other hand, the parakeratotic, and still more the excessively hyperkeratotic areas show the peculiarity of remaining quite free from sweating, even when sweating is elsewhere profuse, as after the administration of pilocarpine. Or, rather, these areas show no sweating externally. Hyperkeratosis of these areas seems to lead to complete occlusion of the sweat-ducts, or if the power of sweating is not entirely lost, the conduction of the secretion to the outside is at any rate made very difficult. The already moist horny layer becomes still more moist by the arrival of continually fresh sweat secretion, and thus the coherence of the horny masses is said by the author to be increased.

A second factor in the formation of palmar keratomata is also associated with the absence of external sweating. The retention of fluid between the horny layers prevents the usual rapid exfoliation of the superficial epithelium, and leads to the heaping up of the horny substance.

A third characteristic of keratomata results partly from the physiological functions of the hand as a prehensile organ, and partly from the great diminution in elasticity which the parakeratotic affection brings about. This diminution in elasticity, especially when associated with any inflammatory affection, leads to a flattening out and disappearance of the normal sulci of the palm, and even to the formation of a homogeneous mass of rigid inelastic material. If now the hand be used for the purpose of grasping objects of any kind, the resulting lines of tension lead to a splitting of the palmar tissues opposite those points where the normal palmar sulci existed. Irregular, jagged, and extremely painful rhagades result, and are perhaps to be looked on as a secondary complication of keratomata rather than as an essential characteristic. Such rhagades are, however, a source of much trouble to the patient and to the physician. As methods of treatment the author recommends preparations of casein, of salicylic acid and borax with spirit and glycerine, and in certain cases salicylic soaps and plaster mulls.

J. L. BUNCH.

EXPERIENCE OF A YEAR'S TRIAL OF THE LIGHT TREATMENT FOR LUPUS. C. M. O'BRIEN. (*The Dublin Journ. of Med. Sci.*, August 1st, 1903.)

IN this paper, read before the Section of Medicine in the Royal Academy of Medicine in Ireland, the author gives an account of the light treatment of lupus as carried out by him in the City Hospital for Diseases of the Skin. The lamp used was a modification of the Lortet-Genoud or French lamp. The usual period allowed for each sitting was 15 minutes, and 12 ampères the amount of current.

Where the susceptibilities of patients allowed, sittings of from 20 to 60 minutes and a current of from 12 to 18 ampères were employed with gratifying results, the reaction in each case becoming more pronounced, and penetration to the deeper tissues more manifest. The writer believes that many of the shortcomings hitherto complained of in the use of the French as compared with the Finsen lamp may be obviated by lengthening the duration of each sitting, while at the same time increasing the intensity of the light. In ulcerating cases, where the pressure of the Finsen method could not be borne, the X-rays were employed until healing had occurred sufficiently to allow further treatment by the ultra-violet rays. In all such cases the X-rays were regarded as a valuable addition to rather than a substitute for the light treatment. The cases treated were not selected, and presented great variety in extent, character, and duration, which varied from three to twenty-eight years. All had been operated upon prior to undergoing the treatment, some as often as fourteen times. All the cases steadily improved; some continue to do so still, and with the latter time would appear to be the only essential necessary, while a good percentage of the earlier cases is already cured, at least in appearance. The writer hesitates to hazard an opinion as to permanency of cure, but thinks the Finsen light in this respect has no superior—an opinion which was strengthened by personal examination of many cases at the Finsen Institute in Copenhagen, which were cured and had remained so for from one to six years. He is further of opinion that in the treatment of circumscribed superficial lupus the Finsen light has no equal, and when judiciously applied ranks among the most brilliant discoveries of modern medical science. Details of four cases, with illustrative photographs, are given.

S. E. DORE.

CUTANEOUS ACTINOMYCOSIS OF THE FINGER. A. SICHARD. (*La Presse Médicale*, August 15th, 1903.)

IN this paper the author gives an account of a case of actinomycosis of the finger in a woman, aged 39 years, who worked in the fields and had the care of cattle. She was healthy and robust, and there was no antecedent syphilitic or tuberculous history.

On August 25th, 1902, while collecting the sheaves of wheat to tie them into bundles, she experienced a sharp pain in her left index finger. A spike of corn happened to cut the skin of the metacarpo-phalangeal groove for about a centimetre and a half. The cut was very clean, quite superficial, and was only followed by a very trifling flow of blood. The patient did not take any further notice of this little accident. She worked as usual the following day without feeling any pain or abnormal sensation. The little wound had cicatrised by the next day.

Eight days after, however, on getting up in the morning, she noticed a painful sensation in the region of the left index finger, which rapidly became œdematous. The œdema increased the day following, and involved the extremity of the finger and the palm of the hand. The pain became very acute, reaching its height in forty-eight hours. Then some vesicles appeared around the old cicatrix, and the skin at this level became red and hot. There was no lymphangitis of the arm, and no axillary adenopathy. A doctor, called in fifteen hours after the cut, eight hours from the beginning of the painful phenomena, noted the formation of an abscess and made an incision, from which a little pus and some blood escaped. Some days afterwards a second incision was thought necessary, and gave rise to

the passage of a more appreciable quantity of pus. The following week a second abscess formed a little in front of the first, on the second phalanx of the index finger. After some time a third focus came to light in the cleft separating the index from the middle finger. The suppuration of the three foci persisted, and fearing that the finger would have to be amputated, the patient came to the hospital on October 14th, 1902. On removing the dressing three sores were displayed. They were deep, sanious at the base, greyish, sloughed in parts, and crateriform at the edges. Pressure gave rise to small drops of pus. In the second focus the ulceration was deeper, the aponeuroses of the muscles were destroyed, and the underlying bare bone could be felt with a probe. A radiogram showed well-marked periostitis and the exfoliation of a small sequestrum. In the pus from one of the foci it was possible to obtain some little yellow granules, but they were very few in number. The lesions of cutaneous actinomycosis have been described as being either nodular or ulcerative, the ulcerative always succeeding the nodular lesions. The author's case does not agree, from the clinical point of view, with this description. The ulceration directly followed some vesicles, and from the first, although open to the exterior, it took on a most severe form, with rapid extension to the deep parts, destroying muscles and aponeuroses and affecting the periosteal and bony tissue. In considering whether the local gravity of the mycotic process should be attributed to its microbic associations, certain writers have contended that the parasite has only a chance of proliferation when it is in contact with certain saprophytes of the integument. According to this view the rapid destruction is owing to the activity of the symbiosis. If, however, one considers the soil and certain individual susceptibilities to the organism, the possibility of different modes of infection can be understood. In the cases with a rapid and grave course, even more than in the visceral localisations, the employment of the iodine compounds, in external applications and taken internally, exercises a favourable influence upon the evolution of the disease, and may be followed by lasting healing.

S. E. DOBE.

EXPERIMENTAL RESEARCHES AMONG THE ANTHROPOID APES. ROUX and METCHNIKOFF. (*Rev. Prat. des Mal. Cut., Syph. et Vénériennes*, Sept., 1903.)

THE study of certain human diseases by experimental research in animals being rendered of but little avail on account of the immunity the test animals in ordinary use apparently enjoy against these diseases, led MM. Roux and Metchnikoff to make use of the anthropoid apes, which are the animals most closely resembling man, in pursuing their investigations on diseases purely human.

In their first experiment a portion of melano-sarcomatous tissue was introduced into the anterior chamber of the eye and subcutaneous tissue of a young chimpanzee.

The sarcomatous tissue did not undergo rapid resorption as in the test animals (rabbits, guinea-pigs, etc.). Ten weeks later no tumour had made its appearance, the animal remaining well. Attacked eventually with broncho-pneumonia, it died in midwinter with symptoms of this disease, but without any manifestation of melano-sarcoma.

In their second experiment they inoculated a young female chimpanzee with the virus of syphilis. The very numerous experiments which have been made to produce syphilis in animals have, up to the present time, produced negative or very imperfect results.

More than twelve years ago Dr. Maurice Nicolle produced a papular eruption in a *Macacus simius*, two weeks after the subcutaneous inoculation of the syphilitic virus. Dr. Charles Nicolle repeated his brother's experiments, and obtained in three of these monkeys, inoculated by frictions on the shaven skin, papules about the seventeenth day.

The eruption was not preceded by the formation of a chancre, convalescence was rapid, and the course of the disease showed nothing in common with typical human syphilis. These experiments were never published. The chimpanzee was inoculated twice—the first time by epidermic scarification in the fold of the prepuce of the right side of the clitoris, with poison from an indurated chancre of about a month's duration. The same day it received in the same way, on the edge of the right eyebrow, a further dose from a second patient, the subject of ulcerating mucous tubercles of the prepuce in the neighbourhood of a healed indurated chancre.

Five days after the two first inoculations the chimpanzee was re-inoculated in the fold of the prepuce of the clitoris on the left side with the scrapings of an indurated chancre of three days' duration only.

The three inoculations gave rise to no immediate lesion. The portals of entry of the poison closed without leaving any trace. For the first three weeks there was no morbid manifestation whatever; but the twenty-sixth day after the introduction of the virus there appeared on the right side, near the clitoris and at the point of inoculation, a small, oval, transparent vesicle, surrounded by a somewhat red zone.

During the following days the vesicle became a punched-out ulcer in the centre of a very distinctly indurated tissue, the base of the form of a rounded plaque, the colour of ochre. In a short time the ulcer became covered with a grey false membrane with very distinct margins.

The glands in the groins began to enlarge, and some days after the development of the indurated chancre those of the corresponding side showed a very marked hypertrophy. Palpation gave rise to no pain.

During the forty-six days of observation no secondary syphilitic manifestation has shown itself. But the facts noted above appeared to be of sufficient interest to warrant an examination of the animal being made by several syphilographers, among them Prof. A. Fournier, Drs. Dantos, Queyrat, and Salmon, without waiting for further results.

A. SHILLITOE.

TREATMENT OF SYPHILIS. GILBERT. (*Médecine Moderne*, December 4th, 1902.)

THE author gives his views on the general treatment of syphilis. He commences mercury as soon as the disease is diagnosed; this may be in the primary, or not till the secondary period. During the first two years mercury alone is given; during the third year mercury and iodide alternately; during the last two

years iodide alone. Total period, five years. Both drugs should be administered by the intermittent method advocated by Fournier. In the first year mercury should be given for two months; then, after an interval of one month, three courses of six weeks. In the second year three courses of six weeks. In the third year two courses of mercury for six weeks, and two courses of iodide of the same duration. In the fourth year three courses of iodide for two months, and in the fifth year two courses of iodide for two months. In certain cases this routine must be altered and iodide given before the third year. These are—(1) when the chancre is much indurated; (2) when the inguinal adenitis is persistent; (3) when there are severe pains in the limbs and severe headache; (4) when there are early tertiary symptoms. Again, mercury may be required after the third year—(1) if the patient has been badly treated with mercury, or not at all; (2) if secondaries recur; (3) if there are severe lesions of the brain or spinal cord; (4) if iodide alone does not give satisfactory results. As a general rule mercury may be given by the mouth. One preparation should not be used exclusively, but changes should be made. Inunction or injection may be employed when the stomach does not tolerate mercury, or when grave lesions appear in spite of internal treatment.

In hereditary syphilis the syphilitic foetus may be treated by giving mercury to the mother. If the mother is herself syphilitic she should of course receive treatment. The same applies if the father is syphilitic but the mother not. In late hereditary syphilis iodide alone should be given to the child. In hereditary syphilis of the newly born, according to the author, the infant should undergo a five years' course of mercury, in the same way as in the acquired disease. Gilbert recommends 1 milligramme of bichloride, increased to $2\frac{1}{2}$. If the mercury is not well borne by the stomach, inunctions of $\frac{1}{2}$ to 1 gramme of mercurial ointment may be used.

C. F. MARSHALL.

NOTES ON THE EMPLOYMENT OF EPICARIN IN TINEA TONSURANS AND TINEA CIRCINATA. VAN HARLINGEN and H. K. DILLARD. (*Amer. Journ. of Med. Sci.*, June, 1903, p. 1012.)

EPICARIN is said to be a condensation product of creasotinic acid and β -naphthol, and to combine the properties of creasote and naphthol. It is a reddish amorphous powder, with a slight odour resembling acetic acid. It is soluble in alcohol, ether, and liquid vaseline. It has usually been employed in the form of a 10 to 20 per cent. alcoholic or soda solution, or in the form of ointment of the same strength. It was introduced in Vienna by Kaposi for the treatment of scabies with excellent results. The chief disadvantage in connection with its use is its irritating properties and great liability to produce a severe dermatitis. In the treatment of ringworm the drug has proved of considerable value at the writers' hands. They employed 10 and 20 per cent. tincture and ointment. The scalp was shaved, and the tincture was vigorously rubbed into every suspicious patch once or twice daily; the diseased hairs were epilated from time to time, and the scalp washed daily with a germicidal soap to prevent the accumulation of dry scales containing the ringworm fungus. By this means it is stated that an average of five weeks was required to cure the disease. It was believed that the fungus was

the large-spored variety, and that no case of the small-spored and more inveterate form came under treatment.

(This large-spored fungus must be of a different type from the *Trichophyton endothrix* which occurs in this country, for it is often more difficult to eradicate than the microsporon, and even with a capable and energetic nurse or attendant to carry out treatment, takes longer to cure than five weeks by other methods.)

J. M. H. M.

**CLINICAL AND HISTOLOGICAL STUDY OF SIX CASES OF
"SYPHILIDES MILIAIRES PÉRIPILAIRES" SIMULATING
LICHEN SCROFULOSORUM AND KERATOSIS PILARIS.**

JONITESCÚ. (*Annales de Derm. et de Syph.*, vol. iv, June, 1903, No. 6, p. 457.)

JONITESCÚ records six cases of the small papular follicular syphilide, with histopathological examination of five of them. This well-known type of syphilide, with its close resemblance to *Lichen scrofulosorum*, was first described in detail by Bazin in 1866 under the name of miliary papular syphilide; but Jonitescú states that, except by Fournier (syphilide papuleuse ponctuée), it has not been sufficiently clearly distinguished from other small papular syphilides.* He thinks that its acuminate lesions situated around hair-follicles, its evolution, and its clinical aspect merit its being classed as a separate type.

According to Jonitescú it presents itself under two aspects—one simulating *Lichen scrofulosorum*, the other simulating *Keratosis pilaris*. Both forms occur as early lesions, or they may be delayed for some months to a year or more. The first form is characterised by a generalised eruption of small red or coppery-red acuminate papules, pierced by a hair, and having a small horny concretion at the summit, and arranged in well-marked circular groupings; in the second form, which resembles *Keratosis pilaris*, the papules are drier and more horny, and rarely in circular groups, but disseminated or forming large surfaces with grater-like aspect.

Histological examination of excised papules showed a perifollicular cellular infiltration, made up chiefly of plasma-cells, with here and there well-formed and imperfect giant-cells—appearances which, except that they are perifollicular, are characteristic of all papular syphilides.

Jonitescú's descriptions correspond with those of Joseph and Unna of the lesions of small follicular syphilides; and similar collections of plasma-cells and giant-cells with perifollicular grouping have been observed by Whitfield in the miliary lesions of a case of corymbose syphilide.

The article is accompanied by photographs of cases and by coloured drawings of the microscopical appearances.

H. G. ADAMSON.

* Fournier, *Leçons cliniques sur la syphilis, etc.* (1881); *Traité complet de la syphilis* (1899). Jonitescú also gives a large number of references to various authors who have described this form of syphilide, and who, it would seem, have sufficiently clearly distinguished it from other papular syphilides. See also Crocker's *Diseases of the Skin* (2nd edit., 1896, pp. 278 and 520), "Small Follicular Syphilide."

ON A CERTAIN FORM OF XANTHOMA. W. MOSER. (*New York Medical Journal*, October 10th, 1903, p. 689.)

THE case reported is one of multiple growths, of a mushroom-like appearance, in an Italian boy. In size the swellings varied from a pea or marble to a hen's egg, or larger. In colour they were bright yellow or yellowish pink; they were not sensitive to pressure and not painful, but by reason of their size and location—chiefly over tendons and bursæ—it was thought advisable to remove some of them. Microscopical examination of the growths showed a yellow fibrous structure, the fibrous tissue predominating over the cellular elements, which were sparse, polymorphic in character, and pigmented. Some cholesterin crystals were present in the growths. The growths under consideration bear no relation to colloid degeneration of the skin (Besnier) or to colloid milium (Wagner), since these occur as small, flat, or slightly discrete, rounded growths, the size of a pin's head or a pea. The patient was at no time icteric, nor did his urine contain sugar; the growths were present for some years without affecting the patient's general health, and Moser lays stress on their surface being smooth and not nodulated, tuberculated, or fissured, and on their brilliant yellow colour.

J. L. BUNCH.

REVIEWS.

THE RÖNTGEN RAYS IN THERAPEUTICS AND DIAGNOSIS.*

THE volume before us is the most complete and up-to-date contribution to the subject of the therapeutic action of the Röntgen rays which has been published in English. It is the combined work of a physicist and a dermatologist who has had a wide experience of the X-rays therapeutically.

The first section of the book, consisting of 215 pages, is technical in its character, and is from the pen of Eugene Caldwell. After a short history of the discovery of the X-rays and a reference to the classical experiments of Jackson, Lenard, Röntgen, Crookes, and Hertz on the subject, the writer briefly describes in successive chapters the essentials of an X-ray equipment, the various types of X-ray tubes, induction coils, and interrupters employed, and the technique of radiography, X-ray photography, and fluoroscopy.

This section is tersely and lucidly written, and every page of it bears testimony to a thorough knowledge of the subject. Valuable practical hints are given from

* *The Röntgen Rays in Therapeutics and Diagnosis*, by William Allen Pusey and Eugene Wilson Caldwell. Octavo. Price 21s. net. Philadelphia, 1903: W. B. Saunders & Co.

time to time, and one feels in reading these chapters that the writer understands not only what he is writing about, but has the somewhat unusual faculty of being able to express himself in simple and direct language.

There is a short chapter at the end of this section which deserves a note in passing. It is entitled the "Choice of an X-ray Outfit," and in it is discussed the type of exciting apparatus and the form of interrupter which should be employed, and the selection of tubes. With regard to the exciting apparatus the author is dogmatic, and affirms that if a 110-volt direct-current lighting circuit is available the induction coil is undoubtedly the best; but when the only available source of current-supply is an alternating electric-light circuit, either a static machine or an induction coil will do equally well.

The second section of the book is entirely concerned with the therapeutic application of the X-rays, and is the work of Dr. William Allen Pusey, of Chicago. He first describes the gross effects of the rays on the skin, such as the pigmentation, which he believes to be the result of the same process which causes tanning from sunlight, and the reaction, which he also considers to be identical with that produced by sunlight. It is somewhat difficult to understand this point of view when one considers the difference in the reaction-time after exposure to X-rays and to sunlight, and also the great difficulty of healing in the case of X-ray burns. He then discusses the deep-seated effect of the rays, and believes that in spite of their great power of penetration they are not so active deep down as on the surface. With reference to idiosyncrasy, which it is customary to regard as playing a most important part in the production of X-ray dermatitis, the writer considers that its influence has been exaggerated somewhat, and that though there may be a difference in susceptibility, it rarely amounts to more than 4 to 1. This seems to us to be somewhat in the nature of a distinction without a difference. He does not consider with Scholtz that different parts of the skin vary in their reaction to the rays, nor does he think that after repeated exposures an immunity to dermatitis is produced. The technique for X-ray exposures is dealt with in detail. The author employs a coil with a 12-in. spark gap, usually a current of $2\frac{1}{2}$ ampères, and a voltage ranging between 20 and 30 volts, depending on the resistance of the tube. He begins with a distance of 15 cm. and gradually reduces it to 5 cm., and commencing with exposures of a few minutes, increases the time to fifteen minutes. The exposures are given daily for two or three weeks, and discontinued when there is any sign of a dermatitis supervening.

The writer discusses in considerable detail the histological changes produced by the X-rays, and believes that they disarrange the intra-cellular structure and finally disorganise it, their action being much more potent in pathological than in the case of healthy tissues. The closing chapters of the book are taken up with a description of the various diseases which have been benefited by the X-rays. The opinions of the various workers on the subject are freely quoted, and the writer's own cases described. In these chapters the writer is reserved and convincing. The volume is well illustrated throughout, both with drawings of the apparatus and skiagraphs and photographs of cases, and the references to the current literature on the subject are adequate. On the whole it cannot but be of the greatest value to all interested in the application and utility of the Röntgen rays in the treatment of disease.

J. M. H. M.

PHOTOTHÉRAPIE.*

THIS small volume is published in the well-known series "Encyclopédie Scientifique des Aide-Mémoire," under the direction of M. Léauté, by Messrs. Masson and Co. and Gauthier-Villars, of Paris. M. Chatin is one of the chiefs of the electro-therapeutical laboratory of the St. Louis Hospital, and M. Carle was formerly *chef de clinique* in the department of skin diseases in the Faculty of Medicine at Lyons. Both are members of the French Dermatological Society. M. D'Arsonval contributes the interesting preface.

Under the conditions we have enumerated the reader will expect a carefully written, prudent, and accurate report, and the expectation is not disappointed. The book is quite modest in its profession, a welcome change in tone from some of the productions on the treatment of diseases by means of light.

The authors in the first chapter give a short account of the physics of light; in the second an appreciation of the effect of light upon plants, bacteria, animals, and the human organism; the third chapter tells shortly of the methods of using the recent apparatus for the application of light in the treatment of certain internal diseases, *e. g.* light baths, Dowsing's method, etc.; while in the fourth part, which is the most elaborate and important, the authors concern themselves with Finsen's method of application of light and its modifications. The volume concludes with a very considerable bibliography of the subject.

This book is a useful guide to those who are dealing with methods of treatment by light. The fairness of its appreciation makes it pleasant to read. We notice, for instance, emphasis laid upon Finsen's protestations against the use of some of the smaller lamps which apply currents of smaller intensity with short exposures, and as a consequence produce insufficient and superficial reactions. For those who wish a general review of the subject it appears that this little volume is peculiarly well adapted.

We hope that the series will be soon enriched by a similar useful volume dealing with the therapeutic effects of the X-rays.

* *Photothérapie. La Lumière: Agent Biologique et Thérapeutique.* By A. Chatin and M. Carle.

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ACUTE CONTAGIOUS PEMPHIGUS IN THE NEWLY BORN. A CLINICAL STUDY.

By GEORGE J. MAGUIRE, M.B., B.A.O.

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LITERATURE in English dealing with the form of pemphigus occurring in limited epidemics amongst new-born infants is of the scantiest. Neither in Allbutt's *System of Medicine* nor in the *Encyclopædia Medica* is there much information upon the subject, and it is dealt with by the writers rather as an interesting curiosity than as a disease coming within the purview of medical science in this country. Nevertheless it is recognised that a form of pemphigus other than syphilitic does sometimes occur, of which Dr. Payne, in his article in Allbutt's *System*,* says that it is "a contagious pustular affection, sometimes fatal, occurring in limited epidemics, which have been observed to follow the practice of a particular midwife. It is local in distribution, occurs exclusively among the poor, and is associated with unclean linen and want of antiseptic precautions." The same authority, in an article published† some years ago upon this subject, had stated, "It is alleged by some and denied by others that there is a second form of Pemphigus neonatorum which is not syphilitic. I am disposed to think it is extremely rare, if not entirely unknown, in this country; nevertheless the descriptions of French and German writers seem to

* Vol. viii, p. 636.

† 'Lancet,' ii, 1893.

show that there is such an affection, which appears sometimes to prevail epidemically, or to be endemic in certain places. It has been thought to be contagious." The "characters seem to delineate a form of disease with which medical men in this country are not familiar. The facts of endemic distribution and occasional epidemic occurrence seem to point to some specific infective cause, perhaps of septic origin."

In the September and October of 1902 an outbreak of this peculiar infection, confined to a comparatively small number of children, but of a high case-mortality, came under observation in the borough of Richmond, Surrey. For many years there has existed in this town an institution, known as the Richmond Lying-in Charity, for the care and relief of the indigent poor during labour and the puerperium. The Society employs a midwife, who, in addition to attending the Charity cases proper, is permitted to conduct a private practice. The holders of the post for the last few years have been competent and thoroughly capable women, trained in a London institution, and holding the certificate of the Obstetrical Society. Latterly the present midwife to the Charity has been permitted to take probationer pupils for training in monthly nursing, and during part of the time of this epidemic had two of these girls living with her. In addition, having been in ill-health for some time, the bulk of her work during the spring and summer had been taken by a deputy, presumably a competent midwife, but one without any certification.

In August and September, then, the work was carried on by this substitute alone; afterwards by her in conjunction with the midwife herself and the two pupils. As, apparently, the first-named and one of these probationers were the two concerned in spreading the contagion, and as I shall have occasion frequently to mention them in the course of this paper, I shall in future refer to them as "A" and "Z" respectively. The last birth in the practice prior to the outbreak of the epidemic was on August 20th, and attendance on mother and child ceased on September 1st. Up to this time, though A had delivered most of the mothers, and had had sole charge for August, no case of pemphigus had been observed. From September 1st, the date of the last attendance on the last case unaffected, until September 10th, no birth took place. On this latter date the baby in whom the disease was first observed was born. From this time until October 23rd, when A

left the district, twenty mothers were delivered; eighteen infants were affected by pemphigus, and of these eight died—a case-mortality of 44·4 per cent.

My connection with the epidemic dates from October 23rd. In the forenoon of that day I saw a baby, No. 9 in the series, which on cursory inspection presented an appearance exactly similar to that brought about by burning. The epidermis over a very large area had exfoliated, leaving a red, raw, weeping surface. The face—with the exception of the eyelids and forehead,—the ears, the neck, and much of the anterior thoracic and axillary surfaces, the groins and abdomen, the nates and genital organs, and the skin over the lumbar region for an extent of some 3½ by 2½ inches, were in this condition. The scalp, arms, and legs also presented smaller circular areas of denuded derma. The scrotum was œdematous. The extremities and lips were cyanosed, the lungs were œdematous and their bases consolidated, there was much dyspnœa, and the child was evidently moribund. It was not possible to do more than give some general directions about warmth and the free use of brandy, and, as a matter of fact, the infant died within four hours of my visit. Learning that A had been attending to mother and child for some days previously, I judged it advisable to write to the Charity's midwife, telling her that it might be wise for A not to take any other cases for a week or so. That same evening the midwife came to me to tell me that A had left the district that morning, and that several other cases were infected. Of these cases I had the care of six, and by the courtesy of the medical attendants, to whom I am much indebted, I was able to interview most of the other mothers and to see the infants that were living. It will be preferable to give certain details respecting each case before discussing the points arising therefrom.

CASE 1.—Male child, born September 10th. Mother delivered by A and baby washed by A each day afterwards. The bullæ were first noticed on September 18th, situated on the chin, thence spreading round the neck; no other portion of the surface became involved. The child was healthy, breast-fed, and took food well all the time. No symptoms of general infection were manifested, and the case went on to complete recovery.

CASE 2.—Male child, born September 12th. Washed by A on day of birth and each succeeding day. A bulla was first noticed on September 19th, on the left upper eyelid. Hence the skin lesion spread to the side of the head, the neck, axilla, chest, legs, and back. The groins and lower abdomen were said to have

been "very bad," but the umbilicus was not involved. Breast-fed, and had no general symptoms. Treated with boracic acid for dusting, it recovered, the only lesions being several thick white scabs on the scalp, the rest of the body was healthy.

CASE 3.—Male child, born September 13th. Washed the infant each day. The first bullæ noticed on the chin, thence spreading to the face, head, and on any other portion of the skin. The child was healthy, presented any general symptoms. Treated simply with boracic acid. Recovery took place. On November 7th the only lesions were a couple of small circular stains on the scalp, left after the scabs had been adherent thereto.

CASE 4.—Male child, born September 19th, the first sign of the disease showed itself on the face. A small pimple was noticed on the cheek. By the next day the face was much inflamed. Rapid involvement of the skin, generally, followed. The face and surface were much excoriated, the navel inflamed, the umbilical men distended. The palms and soles were at first healthy, and breast-fed until the sixth day, when it was changed to feed; from this time until death it was bottle-fed. On the sixth day, and gradually became more frequent. Death set in, and death took place on October 13th. Treatment was by grey powder and inunction with boracic acid.

CASE 5.—Male child, born October 3rd. Mother first noticed on the neck, thence spreading to the face. Regions were affected. The child was healthy, breast-fed through. No general symptoms were noticed. On November 4th there were to be seen the markings of the disease and some crusts on the scalp.

CASE 6.—Female child, born October 6th. Mother first noticed on November 12th, on the left arm. The arm to the head, and to the legs. The groin and abdominal surface was free from any lesion, as was the umbilicus. The child was healthy, breast-fed, and had no general symptoms. Treatment was by daily washing with warm water, crusts being removed by bread soaked in water, and sores dusted with a powder of salicylic acid, zinc oxide, and covered with cotton wool; internally a saline solution of citrae, was given, with grey powder at night. On November 10th the condition was as follows:—Since the last being noticed on November 8th (fourth day made); these vesicles were small, dried up quickly, and the areas of old bullæ there was a faint red stain. The child was healthy.

CASE 7.—Male child, born October 7th. Mother first noticed on October 10th, in the left axilla, the regions affected were the back, the left groin (on the lower portion of the abdominal surface on the

and the head. The palms and soles were unaffected, as was the umbilicus. The child was healthy, breast-fed, took food well all through, and never manifested any general symptoms. Dusting with boracic acid was the only treatment. Recovery ensued, and on November 27th there were no signs of disease anywhere save for two small patches of dry epidermis on the scalp.

CASE 8.—Male child, born October 7th. Mother delivered by A. Bullæ were first noticed on October 11th, on the neck. Thence they spread to the chest and under the arms, but to no other portion of the surface. The child was healthy, breast-fed, taking food well all through, and showing no general symptoms. Treated simply with a local application of olive-oil and lime-water, recovery took place. On November 21st there were left dull red mottled areas, showing the sites of the bullæ.

CASE 9.—Male child, born October 12th. A had nothing to do with the infant until October 15th, when it was washed by her, as it was on the ensuing days. Vesicles appeared on October 19th, and on October 23rd had spread all over the body, the head, and the limbs, leaving, however, the palms and soles clear. The umbilicus was inflamed, and protruded as though there were an umbilical hernia, and the abdomen was moderately distended. The child had been healthy at birth, was breast-fed, and had taken food well until the morning of October 23rd, when it had refused the breast and had vomited at intervals. There was no diarrhoea. Dyspnoea was marked. Death took place in the afternoon of October 23rd.

CASE 10.—Male child, born October 14th. Mother delivered by A. Vesicles were first noticed on the 17th, on the neck and head, quickly becoming generalised. On the evening of October 28th, when I first saw the infant, the condition was very similar to that in Case 9. The skin generally was diseased

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CASE 13.—Male child, born October 15th. Mother delivered by A first noticed on October 18th, appearing on the neck. Thence they spread to the head, the face (involving the conjunctivæ), the axillæ, the groins, the buttocks, the scrotum. Neither palms nor soles were affected. The groin and abdominal surface were much excoriated, the umbilicus was inflamed and protruding, and the abdomen was distended. The infant had been healthy, was breast-fed, and took food well till October 31st, when sickness began. On the day or two at this stage there was slight diarrhoea. Later, dyspnoea became more and more marked, cyanosis, and so-called convulsions were observed. Child was treated as follows:—A bath morning and evening of weak wash of potassium permanganate, boracic acid dusted freely over the denuded parts with lint smeared with boracic ointment laid on, envelopment of the body in cotton wool, and constant application of external heat; internally, gr. half-grain doses three times a day, and brandy freely, half an ounce being taken in the twenty-four hours. Whether the effect of this treatment was not, life was prolonged till November 5th, when death took place.

CASE 14.—Female child, born October 16th. This case was not attended by A, the infant being washed each day after delivery by B. Bullæ were first noticed on October 22nd, appearing on the neck; later they spread under the chin, involving the ears, and under the arms. The palms and soles were not affected. The groins were said to have been involved; a spot appeared at a late date on the umbilicus one spot. The child was breast-fed, and took food well all through. Complete recovery took place, only traces of the disease apparent on November 15th being two large stains on the back of the neck, corresponding to the sites of the ears. The groins and umbilicus showed no signs whatever of having been affected.

CASE 15.—Male child, born October 17th. Mother delivered by A. Bullæ were first noticed on October 19th, on the neck. These rapidly generalised, confined to any area, but the palms and soles were free. The groin and abdominal surfaces were badly excoriated, the umbilicus was inflamed and protruded, the abdomen was moderately distended. The child had been healthy, was breast-fed, and took food well till the 27th, when sickness set in. There was no dyspnoea present towards the end, and convulsions were said to have been observed. The infant was seen in the evening of October 28th, and treatment as in Case 10 was ordered. As in this case, however, death took place a few hours later.

CASE 16.—Female child, born October 22nd, on which date it was washed. Bullæ were first noticed on October 26th, appearing on the back of the head. They were confined to the head and neck, except for one spot on the chest. The palms and soles were free, as was the umbilicus. There was not much abdominal distension. The child was healthy, breast-fed, and at all times took food well. No general symptoms were manifested. The treatment was as in Case 13, recovery taking place. On November 7th the diseased areas were drying up and healing, nor were any fresh blebs appearing on any part of the healthy epidermis. On November 19th the skin merely showed staining as in the other cases that recovered.

Feeding of infant.	Food taken	Result.	Other Patients—adults and children—infected by each case.
Breast	Well all the	Recovered	Mother, brother, and woman washing soiled clothes.
"	"	"	Mother : two spots under chin, appeared 15 days after infant's first bulla, and lasted 7 days.
"	"	"	Brother, 2 years old, on buttock.
"	Well till sixth disease	Died Oct. 13	Mother, on hands.
"	"	Recovered	Baby in neighbour's house, on body ; girl nursing this child, on hand.
"	"	"	None.
"	"	"	Mother, one spot.
"	"	"	None.
"	Well till 36 before death	Died Oct. 23	None.
"	Well till Oct. after this bulla	Died Oct. 29	None.
Breast till Oct. 26th ; after this date bottle-fed	Well till late	Died Oct. 31	None.
Breast	"	Recovered	None.
"	Well till Oct. after this bulla	Died Nov. 5	Mother, on hand.
"	Well all thro	Recovered	None.
"	Well till Oct. after this bulla	Died Oct. 29	None.
"	Well all thro	Recovered	Brother, 2 years old, on arm.
"	Well till Oct. after this bulla	Died Oct. 29	None.
"	Well till Oct. after this bulla	Died Oct. 31	Mother, on breast.

CASE 17.—Male child, born October 22nd. Mother delivered by A. Vesicles were first noticed on October 25th, on the neck, and rapidly spreading. The groins and abdomen were much involved, the umbilicus was inflamed and protruded, and there was some abdominal distension. The palms and soles were not affected. The child was healthy at birth, breast-fed, and took food well until October 28th, on and from which date it showed disinclination to feed, and sickness began. There was not any diarrhoea. Dyspnoea followed, and was very marked in the forenoon of October 29th, when I first saw the infant. The so-called convulsions were also observed. Similar treatment to that in Case 13 was ordered, but death took place early the same evening.

CASE 18.—Female child, born October 22nd. Mother delivered by myself. A was not in attendance, but next morning washed the infant, her last work in the district. Three days after, on October 25th, a bulla appeared on the neck. The disease rapidly became generalised, the groins and abdomen being very badly excoriated. The umbilicus was inflamed and protruded, and there was moderate abdominal distension. The palms and soles were free from vesicles. The child was a perfectly healthy, normal infant, and was breast-fed. Up till October 30th food was well taken, but on and from that date the child refused to take the breast; sickness set in, with slight diarrhoea; dyspnoea was noticed on the 31st, and on the evening of that day death occurred. Treatment was as in Case 13.

The facts that these cases arose within a definite period, were confined to the practice of a certain midwife, ceasing on her removal from the district, and presented certain common symptoms, point to the conclusion that they arose from a common contagion of septic origin, the transmitting agency being the midwife in question. For with the exception of one case, No. 14, and two infants born during the epidemic but not developing the disease, all the children were handled by her before the signs of infection were apparent. Twelve infants out of seventeen she conducted the delivery of, and these and the remaining five were washed one or more times by her. More than this—from September 8th till October 8th she had sole charge of the practice without any assistance; on and from the latter date Z aided in the care of the children. How Case 14, with which A at no time came into contact, became infected, is a little difficult to explain. As Z was attending to all the infected children it is to be assumed that the contagion in this instance is traceable to her. On the other hand, she also attended to the two babies who did not develop the disease. One infant was born on October 11th, and washed by her every day until the 21st, when the attendance ceased; the other infant, born on October 23rd, was washed by her on the 24th and 25th. It is difficult to reconcile these facts, but the explanation probably is this—that Z

used in washing Case 14 the same flannel apron on which one of the infected cases had been laid not half an hour previously.

Additional proof of the contagiousness of the disease is afforded by a number of cases, adult and juvenile, in which the bullæ appeared. Of Case 1 the medical attendant wrote me, "The disease was evidently contagious. The mother, her son, and the person who washed some of the baby's clothes were all sufferers from it afterwards." In Case 2 the mother stated that she had had two vesicles under the chin, similar to those on the infant, but causing much itching, appearing fifteen days after the first bulla on the child, and remaining seven days. No sign of these vesicles remained on November 2nd, when I saw her. In Case 3 a boy two years old developed bullæ on the left buttock and flank. A napkin, worn once by his infant brother, slightly stained by urine, but otherwise unsoiled, had been put on him unwashed. Soon after the bullæ developed, and on November 7th the following was the appearance presented:—On the left buttock were four circular, discrete, bluish-red marks, three each as large as a halfpenny, the fourth about the size of a threepenny piece. On the body, running from about the middle of the iliac crest on to the abdominal wall, were three or four others, which had been confluent. The skin over these discoloured areas was quite healthy. In Case 4 the mother developed bullæ on the hands, of which traces were visible on November 4th in small circular patches of dried exfoliating epidermis. In Case 5, A having ceased attending on September 29th, the infant was washed from this date by a neighbour. On October 10th a baby of 7½ months that this woman was nursing developed the disease, a large bulla appearing on the thigh. The discharge from this, being conveyed to other parts, brought about a general distribution of the eruption. And from this child a girl of twelve, living in the same house, contracted the disease. For having on one occasion replaced on the baby's arm a bandage that had become disarranged, some of the discharge was smeared over a cut on the middle finger, considerable itching being felt at the time. That night a large bulla developed on the skin around, remaining irritable for some time. On November 21st the state of these children was as follows:—Over the baby's skin, corresponding to the sites of the blebs, were large, circular, dull red stainings; the skin, however, was healthy. The girl showed a large abraded area on the right middle finger, red, dry,

and shining, over which the skin had evidently lost the superficial epidermic layer. In Case 7 the mother developed one vesicle on the left wrist, fourteen days after the first manifestations in the infant, and three days after the first occasion on which she herself washed it. In Case 13 vesicles developed on the hand of the mother. She had washed her baby for the only time on October 28th. On November 7th three foci of infection were noticed on the right hand, one on the tip of the little finger, the others on the third finger at the junction of the distal and middle phalanges, all on the palmar aspect; the two on the third finger became confluent, forming one long bulla. These blebs had all disappeared by October 19th, and no more developed. In Case 16 a brother of the infant, two years old, showed on November 12th a large circular patch of denuded derma, red and weeping, on the inner side of the flexure of the left elbow. This had begun on November 5th as a vesicle, and had pursued a course identical with that followed by the skin affection in the infant. Finally, in Case 18 the mother developed a very small vesicle on the inner upper quadrant of the right mamma, about one inch from the nipple areola.

In addition to these cases of contagion, both Z and her fellow-pupil showed slight infection, Z having one small mark on the left forearm, and the other girl two vesicles on the face and one on each hand.

The source of the contagion is not clear. I was unable to interview the deputy midwife, so that my information concerning her came through an intermediary. Apparently she suffered from a pustular acneiform eruption, sometimes to a greater degree, sometimes to a lesser, never during all the time she was in Richmond being quite free from pustules. Possibly this was the fount of infection, but as no case arose until September 18th, although for months previously this woman had attended the majority of the confinements and infants, one must reserve judgment on the point. It is quite possible the infection arose from the surroundings of Case 1, and it is of interest to note that the medical attendant of this patient says, "About one and a half years ago I had a case of the same kind about fifty yards from her (the mother's) house, which I then attributed to insanitary surroundings."

The contagion must have been conveyed in one of two ways—either on the hands or the aprons of the midwives, for each child had its own washing materials. In this connection it is noteworthy that in thirteen

cases the first bullæ noticed were on the neck ; of the other cases, two showed them on the chin, one in the left axilla on the dorsal aspect, one on the left arm, and one on the left upper eyelid. That is to say, fifteen of the eighteen cases showed the first signs of infection over areas where the hand is placed to support the child in the bath ; and as sufficient pressure is exerted at such a time to rub off the superficial epidermic cells from the delicate skin of a new-born infant, a nidus for the entrance of septic micro-organisms is provided. Should either the supporting hand or the apron on which the child is laid be infected, one can readily see how cases arise.

Previous epidemics of Pemphigus neonatorum that have been investigated have been shown to be due to various micrococci. Bulloch, in the *British Journal of Dermatology* for 1896, discussing the bacteriology of a series of cases of Pemphigus acutus, refers to this point. Summarising the work done up to the time at which he wrote, he states that in 1876 Röser found micrococci in the contents of the bullæ ; in 1881 Gibier found short chains of cocci ; in 1884 Colrat found diplococci, an observation repeated in 1887 by Zechmeister, who considered the organism identical with that isolated by Demme from a series of cases of Pemphigus acutus in adults ; in 1890 Strelitz found two organisms, one giving a golden-yellow growth on culture media, the other a milky-white, a result he obtained again two years later in another epidemic ; and lastly, in 1891 Almquist came to the conclusion that an outbreak of Pemphigus neonatorum coming under his observation was due to infection with the *Staphylococcus pyogenes aureus*.

In the epidemic now under consideration serum from two separate sources was examined. On October 29th, from a bulla in the groin in Case 16 some of the contents were drawn off. A sterilised capillary tube—one of those sent out by the Jenner Institute for the collection of blood serum to be tested for Widal's reaction—was taken, the ends nipped off by sterilised forceps, and one extremity plunged directly into the bulla. The tube having been partially filled, the ends were sealed in a flame, and it was at once sent off to the laboratory of Mr. G. L. Eastes, in Queen Anne Street, with the request that the organism or organisms present should be isolated. On November 3rd the following report was made :—"The serum from pemphigus bulla for bacteriological investigation received at the laboratory on October 30th, was

inoculated into various culture media, and incubated aërobically and anaërobically, and pure cultures of the *Staphylococcus pyogenes aureus* have been obtained." Nor had any other organisms shown themselves in these cultures up till November 30th. On November 11th some of the contents of the bulla on the hand of the mother of baby No. 13 were taken in the same way, and sent to Mr. Eastes, the source of the serum not being stated. The bleb being small, and the contents rather viscid, very little material was obtained; and the report furnished on November 19th states, "The amount of material transmitted was so small that only one culture could be made, and one unsatisfactory cover-smeear preparation. From the culture made on agar the *Staphylococcus aureus* only was obtainable."

Here, then, in two cases, whose only connection was that the infants were affected by the same infectious disease, and whose only intercommunication had been through the nurses A and Z, the same micro-organism was found. The balance of probability is against this being merely a coincidence, and we may fairly assume that the cause of the disease in both cases was the specific micro-organism present. Further, from a study of the course of the epidemic, of the symptoms manifested, and the lesions presented by those affected, from the similarity of the post-mortem appearances in the two cases examined, and from the microscopic appearance of the skin in Case 10, the inference suggests itself that, had all the cases been bacteriologically examined, the same *staphylococcus* would have been found in each.

Assuming, then, that the infective agent was the *Staphylococcus pyogenes aureus*, and that it was conveyed from infant to infant in the manner suggested, the question of the period elapsing between inoculation and the development of a bulla upon the site first arises. The earliest day after possible infection on which any child showed marked symptoms was the second; only one case, No. 15, had bullæ as early as this. In Cases 7, 10, 13, 17, and 18 the skin lesion was noticed on the third day; in Cases 8, 9, 12, and 16 on the fourth day; in Cases 3, 5, and 6 on the sixth day; in Cases 2, 4, and 14 on the seventh day; in Case 1 on the eighth day; and in Case 11 on the ninth day. It would seem that the time elapsing between infection and development of the bulla on the site of inoculation is one varying from two to four days. As we do not know the date on which A herself became infected, we cannot take into account Cases 1, 2, and 3. Of

the remaining cases, all but five have this apparent incubation period. The delay in Cases 4, 5, and 6 may be due to a less virulent infection in the earlier cases. Certainly all cases tended by A after October 7th have this two-to-four-day period, for Case 11, though not developing bullæ until the ninth day, is known positively to have been washed by A on the sixth day. In connection with the early cases it must be remembered that no information whatever has been obtainable from A. The only evidence as to dates of appearance of lesions is derived from the mothers, and it is quite possible that the bullæ had formed some days before their attention was directed to the unusual condition. Therefore the discrepancy between 4, 5, and 6 and the other cases may be apparent, not real. Case 14 was, as we have seen, tended entirely by Z, and the date on which contagion was conveyed is not approximately ascertainable. The period elapsing between inoculation and the earliest naked-eye signs of a commencing bulla is considerably less than three to four days. For the disease does not appear to have been at any time observed until a bulla had formed. The pink macule on the skin that precedes the appearance of this is liable to pass unnoticed. It will later be shown that each bulla begins as a small red spot, easily overlooked, and showing itself some twelve to thirty-six hours before the separation of the epidermal layers and formation of blebs takes place.

The one symptom common to all the cases was the skin affection; nor was there any other manifested in those infants that recovered. In all the cases that went on to a fatal termination there were other signs, forming a group of easily recognisable and similar symptoms, the whole composing a clinical picture of definite outline. First describing in detail the skin lesion, we shall afterwards take up the symptoms peculiar to the group of fatal cases.

In his little work on diseases of the skin, Dr. Liveing* thus refers to what is probably this form of pemphigus:—"There is a variety of bullous eruption described by the late Mr. Naylor as 'Pompholyx diutinus in children.' He says, 'The first sign is usually an eruption of several minute red spots on the surface, generally of the abdomen and thighs, and afterwards on any part of the body. In the course of a day or two each becomes the seat of a small vesicle not larger than a pin's head, and contains a clear fluid; it is

* *Handbook of Diseases of the Skin*, R. Liveing, edit. 5, 1887.

surrounded with a narrow red margin. The vesicles enlarge rapidly and to such a degree as to attain, many of them, the diameter of a hazel-nut in the space of twenty-four hours or less. It not infrequently happens that long ere the vesicle has reached this size it bursts, but the red spot on which it has evolved still spreads, and in a circular direction ; in this manner it may attain one and a half inches or more in diameter.' "

X

The vesicles in the cases now under discussion pursued a very similar course. As before stated, in all cases the first observation was made when serum had collected under the skin. One mother said that the spots appeared as "a glassy pimple, spread rapidly, and came to water;" another, that they were like "little bladders with matter in them." Usually they were said to commence as "watery blisters," or "clear water blisters."

In those vesicles that I observed from their first appearance the following was the course :—A small, circular, pale pink macule formed, not unlike the spot left after a flea-bite, and about that size or a little smaller. As this gradually enlarged the skin over its surface, except for a very narrow areola, became pale and slightly wrinkled, looking not unlike the pellicle forming on boiled milk. This was evidently due to the separation of the layers of the epidermis, and denoted the commencing formation of a bulla. Enlargement went on rapidly, more or less serum collecting, until the vesicle was from half an inch to one inch in diameter, when almost invariably rupture took place, the covering layer being abraded and the contents discharging. There was left a round, red, moist, smooth, glistening patch, identical save in colour with the denuded surface in gangrene. This patch was surrounded by a bright pink border, one eighth to half an inch wide, separating it from the healthy skin. Over this areola the superficial layers of skin were easily removable by moderate pressure, showing that the process of cleavage had gone on here also. Enlargement of the areas went on by a uniform extension of this areola, denudation at the same time taking place from within out. When the extending edges of two bullæ met they coalesced, an irregularly circular or oval patch resulting.

In the cases that recovered, extension did not continue for long, and the denuded areas became dull, paler in colour, with or without a yellowish incrustation, dry, and the superficial epidermis at the borders

no longer exfoliated. The areola disappeared or became indistinguishable from what had been the weeping surface; and after a time, varying from two to six or eight weeks, the site of the lesions was marked merely by a reddish staining of the skin, having the outline and extent of the erstwhile denuded areas.

In the fatal cases, on the other hand, no drying or paling of these areas took place. They remained continually moist, even although dusted with an antiseptic powder, until the death of the infant. Extension went on unchecked, so that relatively enormous areas became involved. Further, it was observed in these cases that as the fatal termination approached, clearance of the skin took place in various situations where no inflammatory macule was originally noticed, and the resulting vesicle had no pink areola. The fluid contents, too, in these bullæ were very scanty, and greyish yellow rather than yellow or golden. It would seem as though the specific infection had found its way in the blood to the deep epidermal layers, and there exerted its action, the local extension becoming a minor factor. And it is noteworthy in this connection that at the post-mortem on Case 11 the skin on the body, even where apparently healthy, exfoliated readily under slight pressure of the fingers.

That in the recovering cases, and through the greater part of the duration of the disease in the fatal cases, new bullæ arose by local contagion, is evidenced by the sites of these. It has above been pointed out that the original lesion made its appearance at some point of pressure, situated almost invariably either on some fold of skin, or where two surfaces were frequently opposed. On the healthy skin that rubbed upon the diseased area a fresh bulla soon made its appearance, and pursued a similar course. The vesicles were always in regions where there was this friction of surfaces or chafing of the skin, and never in any other situation. Thus they were found generally upon the neck, in the axillæ and groins, on the genitals, nates, inner aspect of thighs, and the flexures of the elbows and knees. The face, the back from the sixth cervical to the lower dorsal spines, the shoulders, and the scalp were rarely; the extensor surfaces of the forearms and the legs, the palms and soles, and the forehead were never, involved. The following notes, made when performing the autopsy on Case 11, give an excellent idea of the extent and distribution of the skin lesions in one of the severe and fatal cases. The

superficial epidermic layers had disappeared from the cheeks, nose, and left ear; from the flexures of the elbows; from the right upper arm; over the whole abdomen, limited by the costal margins above, and extending downwards across both groins and for two inches down the thighs, extending also round the dorsum, following above the line of the ribs as high as the sixth dorsal spine, and downwards passing over the buttocks to end halfway down the posterior aspect of the thighs, involving the genital organs. The whole of the left leg posteriorly, from knee to ankle, was denuded, as was the right leg from knee to toes except for a small strip on the outer side running from the inner side of the foot to the outer malleolus.

The exfoliation was due to horizontal cleavage of the epidermis between the stratified and the Malpighian layers. This was well exemplified in the microscopic slides prepared respectively from sections of a new or recent bulla, and one of long standing, taken from the skin of the baby the subject of the first autopsy. The section from the new bulla stained with hæmatoxylin and eosin showed all the layers of the epidermis to be present, but separated over a considerable extent, the separation being seen to have taken place along the lower edge of the stratum lucidum; no necrosis or degeneration of the tissues had as yet arisen. Beneath the Malpighian layer the vessels of the skin were thrombosed, and there was some round-celled infiltration. No micrococci, however, were discoverable in these vessels or in their neighbourhood in the corresponding section stained by Gram's method, although there were scattered micro-organisms along the whole length of the free edge of the Malpighian layer. In the sections from the old bulla some necrosis and considerable degeneration of tissue were noticeable. The epithelial tissues of the skin were wanting, and the subcutaneous tissue was degenerated, with thrombosed vessels, some free hæmorrhage, and much small-celled infiltration. In the section stained by Gram's method the degenerated and necrosed area was seen to contain large numbers of micrococci, arranged occasionally in groups, but not in chains. Most abundant on the surface of the necrotic area, they became less numerous towards the deeper part, though still to be found in it.

To the naked eye there was no infiltration of the erythematous edge of the bullæ, nor was ulceration manifest until the latest stages; these facts alone would serve to distinguish the disease from pemphigus of

syphilitic origin. Add to this that no history of syphilis was obtainable in any case, nor were there any concomitant evidences of this malady, and any lingering doubts as to the presence of this causal agent are dispelled.

The additional symptoms manifested by the group of fatal cases were those of an acute toxæmia. In each of these infants the groins and lower abdomen were much diseased, and extension to the umbilicus followed. This, still an unhealed surface in these recently delivered infants, became inflamed, and so much swollen that an umbilical hernia was simulated. Distension of the abdomen followed, varying in degree, but more marked the longer the child lived, reaching its maximum in Case 13. These were the only signs for some days, and the children seemed well, taking the breast readily. Then a disinclination to feed was observed, with vomiting after a meal. This vomiting became persistent, though at long intervals, and occurred though no food was being taken. Then the lungs gradually filled with serum, increasing dyspnoea with cyanosis was noted, and finally, within from twelve to thirty-six hours after the first attack of sickness, death took place, ushered in by what were termed by those nursing the children "convulsions"—really evidences of the waterlogged condition of the lungs, and the embarrassment of the breathing and the heart's action. The one exception to this course of events was Case 13, where the infant lived five days from the onset of sickness.

That the unhealed stump of the umbilical cord was the path by which the micro-organisms gained entrance, and that the above-detailed train of symptoms was resultant on this and evidenced a general toxæmia, admits of little doubt. In none of the cases that recovered, except in No. 14, was the umbilicus affected. In Case 14 a bleb is said to have appeared in this region three weeks after delivery, when complete healing of the stump had taken place, and when the infant had almost completely recovered from the disease. In every one of the cases ending fatally the umbilicus was inflamed as already described, and this inflammation was in each case followed by similar symptoms. At the autopsy in Case 11 the umbilicus, with a portion of the round ligament, was removed and examined microscopically. The report on this specimen is as follows:—"In the deeper parts of the fibrous tissue removed with the umbilical scar is seen a cleft resembling a lymphatic space, but without any definite endothelial

lining. Along the edges of this are to be found a few scattered micrococci, which stain by Gram's method, and appear, from a study of the whole specimen, to be confined to this cleft. There is a prolongation of this cleft shown in the section, along which the micrococci can also be found. Inasmuch as in the neighbourhood there are vessels containing ante-mortem clots, and as the location of the cleft is in the deeper structures, these facts suggest that the original point of infection was the umbilicus itself."

As to temperature in these cases, nothing very definite can be said. Only three imperfect series of observations have been recorded, in Cases 13, 16, and 18. In the first of these the body-heat was noted from the morning of October 29th, the eleventh day of the disease, until death on November 5th. During that time the temperature was subnormal, except on the evening of October 31st and the morning and evening of November 1st. On these dates the record was 100° F. each evening and 99° F. the intervening morning, dropping to 98° F. the morning of November 2nd, and the day before death being 96° F. In Case 16 observations were made from October 29th, the third day of the disease, until November 10th. Until November 4th the temperature was subnormal; from this date normal until the record was no longer kept. In Case 18 the temperature was noted from October 28th, the third day of the disease, until death on October 31st; and here again was subnormal save on one occasion, the evening of October 30th, when it just reached 98.4° F. It was noticed further that just before death in both the fatal cases the thermometer registered *below* 96° F. One might infer that a subnormal temperature is to be expected in cases of this nature, at any rate after the disease has become established; and the point becomes of importance in considering the treatment to be followed.

As already stated, autopsies were made on the bodies of two infants, Cases 10 and 11. In both cases the appearances of the internal organs were the same, the distribution and extent of the skin lesion only differing; and the following notes are applicable to both.

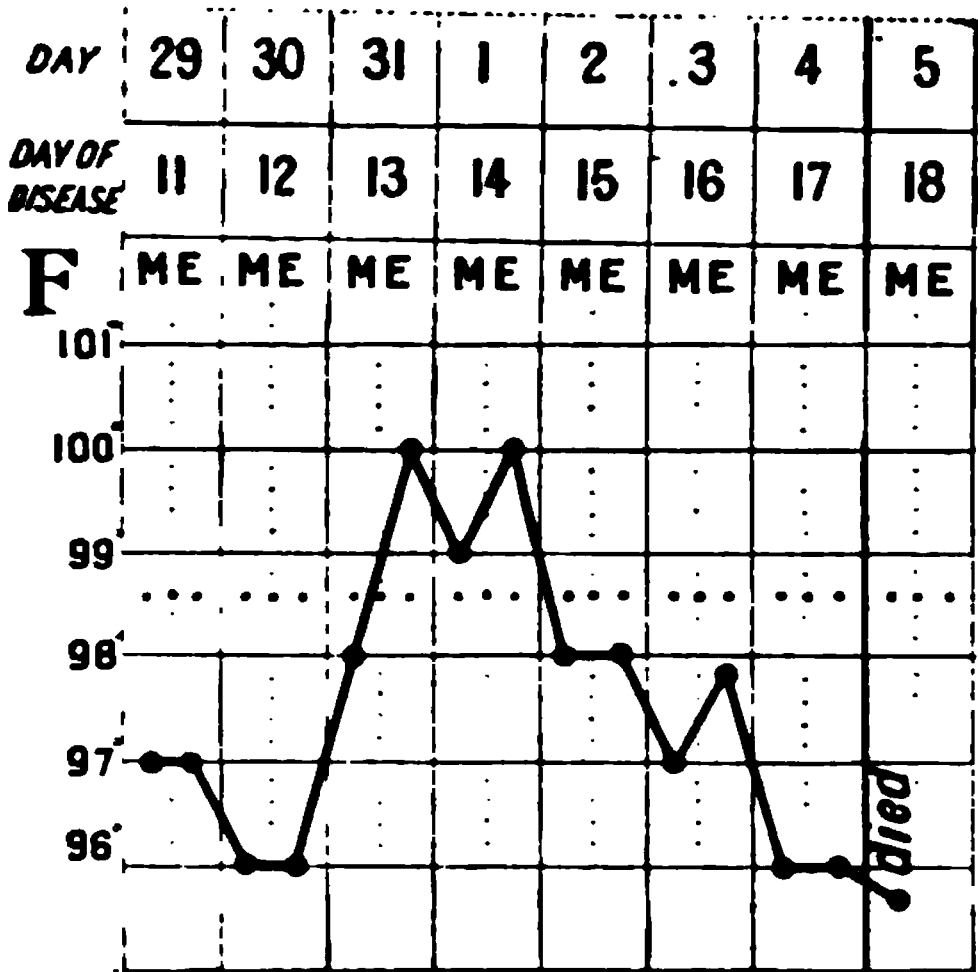
The pericardium contained a small quantity of fluid. The heart was normal in size and structure; its cavities were full of blood. The coronary vessels were engorged.

The lungs were congested, and exuded a blood-stained serum on

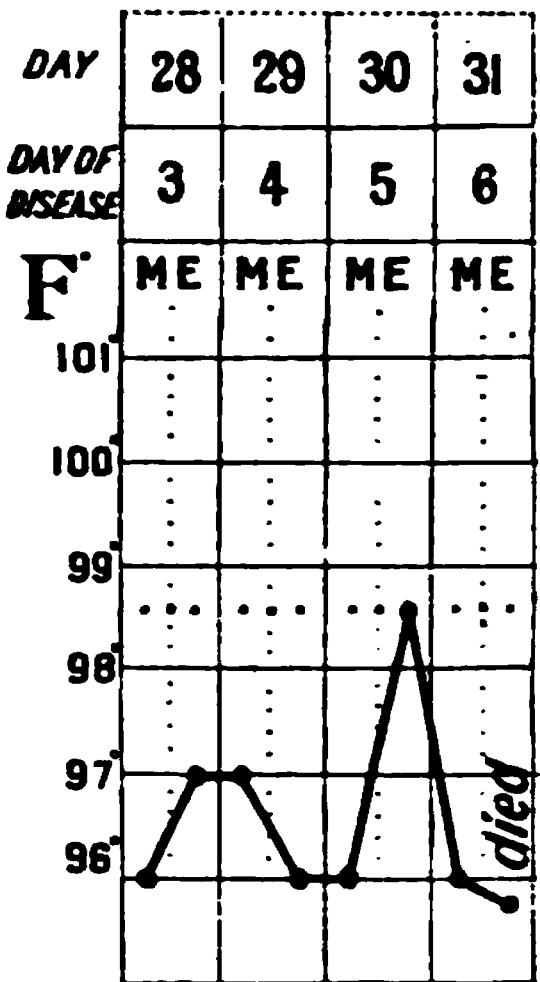
section. The left lower lobe was partially, the right lower lobe entirely consolidated.

The liver and kidneys were congested.

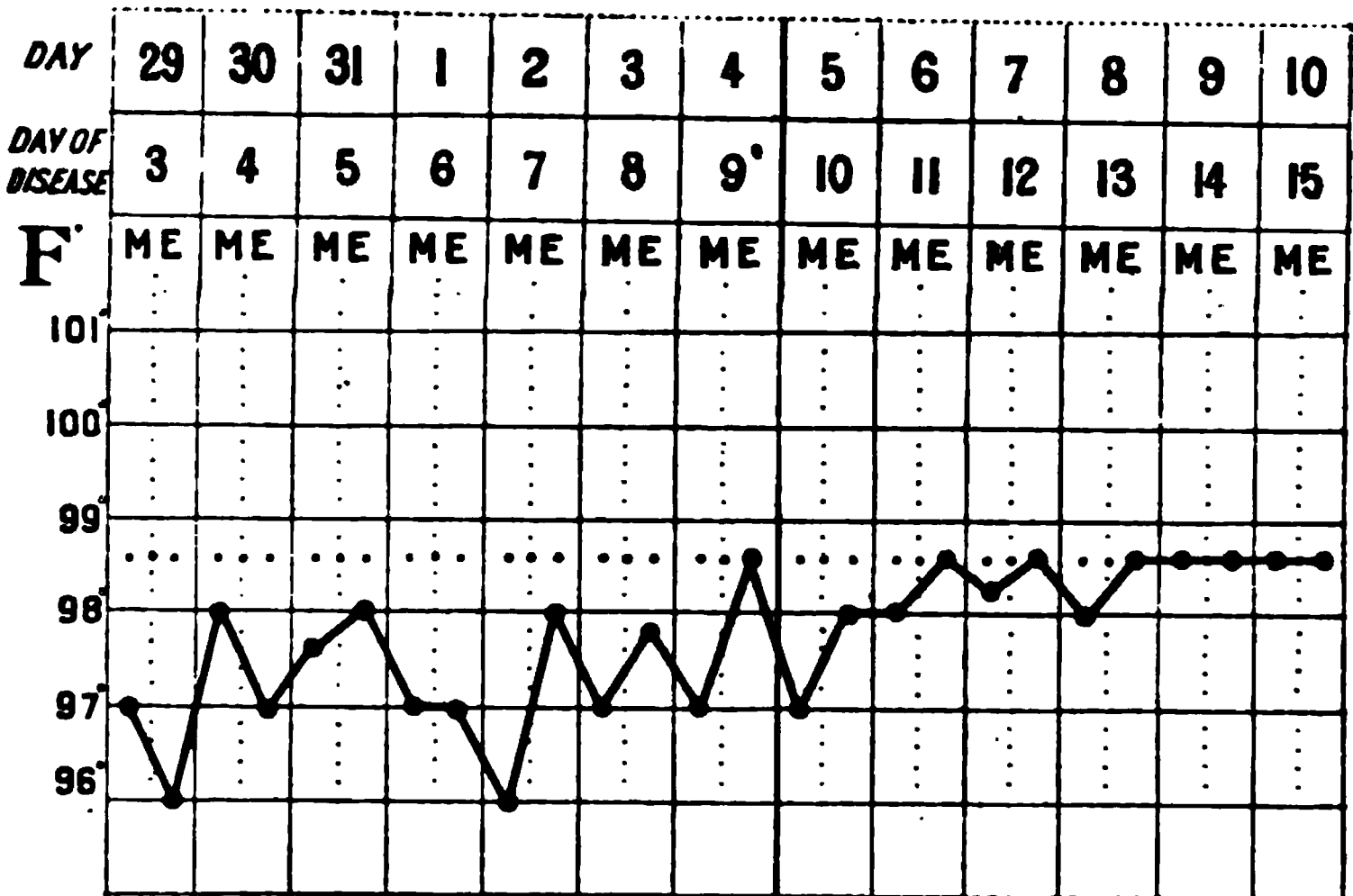
CASE 13.



CASE 18.



CASE 16.



The intestines were distended and full of gas, as was the stomach. The mesenteric vessels were engorged.

No inflammation of any capsule or investing membrane was found.

The skull was not opened in either case.

From the mouth and nostrils of both infants a bright yellow fluid ran out on pressure. A similar discharge was noted shortly before death in some of the other cases, running from the mouth and nose, or vomited.

Sections were prepared from the liver in Case 11. The structural appearances were merely those of acute congestion ; no bacteria were discoverable.

The therapeutic measures adopted in the epidemic were tentative ; nor could they have been otherwise, because of the obscurity veiling the disease. It was not possible to do more than treat symptoms, and even here the methods were haphazard and uncertain. No statements as to treatment in Cases 1, 5, and 12 are forthcoming, further than that boracic acid was used as a dusting powder. This was the only remedy applied in Cases 3 and 7 also. Case 2 was thus dealt with locally, with small doses of grey powder internally. Case 8 was painted with a mixture of lime-water and olive-oil, no drugs being given by the mouth. Cases 4 and 11 had half a grain of grey powder twice a day, and free inunction with mercurial ointment. Cases 10 and 15 were given Fowler's solution in doses of one minim every two hours, and ten minims of brandy every four hours. Cases 6 and 14 were treated by daily bathing in plain water, grey powder being administered at night; and a dusting powder of oxide of zinc, salicylic acid, and starch powder was used, unhealthy areas being painted with a weak solution of nitrate of silver, and covered with a layer of white precipitate ointment. The remaining cases were immersed daily for five minutes in a weak warm solution of potassium permanganas, the skin afterwards being dusted with boracic powder and smeared with boracic ointment; the child was then enveloped in cotton wool and kept very warm. Grey powder was given in half-grain doses three times a day, and brandy administered freely. That warmth and brandy are most valuable adjuncts Case 13 proves. In addition to being enveloped in wool, the infant was kept in constant contact with hot-water bottles, and took about half an ounce of the spirit in the twenty-four hours. This child lived five days from the onset of what came to be recognised as symptoms of approaching death.

Looking back upon this epidemic, it would seem that the treatment offering most hope of a successful result might be somewhat as follows :

Remembering that without general infection recovery ensued, while with it death was inevitable, and that the infection became general through the channel of the unhealed umbilicus, the first indication is to keep the stump scrupulously aseptic, protected by some efficient antiseptic dressing. For the treatment of the skin lesions it might be found that a daily warm bath in a weak solution of creolin (ten to thirty minims in two to four gallons of water), or of permanganate of potash (five to fifteen grains in two to four gallons of water), would be beneficial. The infant should be completely immersed, save for the head and face, and kept in the liquid five or ten minutes. Drying should be rapid and careful, and the raw surfaces should be freely dusted with boracic acid and starch powder, or some other bland antiseptic dusting powder, and afterwards covered with a thin layer of a mild antiseptic ointment. If the child were then warmly swaddled, and kept very warm, no further treatment probably would be necessary. If internal medication be apparently indicated, brandy in small doses, with perhaps a little grey powder or Fowler's solution, could be given.

Should, in spite of care, the umbilicus become infected, and the train of symptoms earlier described ensue, artificial heat and the free use of brandy would probably be the best remedies, although a great deal of benefit could not be expected. It is possible that in small doses of a polyvalent antitoxic or antimicrobial serum the only certain specific would be found.

It scarcely needs to be added that the most scrupulous antiseptic precautions should be observed by all who come in contact in any way with an infected case.

Summing up, the conclusions arrived at were—

1. That this epidemic was one of the comparatively rare disease *Pemphigus acutus neonatorum*.

2. That it was due to infection with a pathogenic micro-organism, the *Staphylococcus pyogenes aureus*, conveyed from case to case by a certain midwife.

3. That though appearing chiefly in the newly born, and only fatal to these, it also attacked older children and adults.

4. That it was characterised by a bullous eruption on the skin, variable in distribution and extent, the specific micro-organism being found in the contents of the vesicles.

5. That in many of the cases no symptoms other than the skin eruption were manifested, but that a certain group of cases showed grave symptoms of a general infection, and invariably ended fatally.

6. That the point at which the systemic invasion arose in these fatal cases was the unhealed umbilical scar.

7. And that treatment to all appearance had little or no effect upon the course and duration of the disease, whatever the result.

PEMPHIGUS NEONATORUM IN THE LIGHT OF RECENT RESEARCH.

By H. G. ADAMSON, M.D., M.R.C.P.,

Physician to the Skin Department, Paddington Green Children's Hospital.

PEMPHIGUS neonatorum has long been regarded as a contagious disease. As recently as 1888, however, so experienced a clinical observer as Henoch considered the infectious nature of the disease to be "scarcely established." By Bohn it was ascribed to the use of too hot baths. Parrot and others regarded it as "cachectic." But clinical evidence of the contagiousness of the disease continued to accumulate until at the present time it is generally recognised that it is altogether distinct from true pemphigus, and by most writers it is classed with Impetigo contagiosa of Tilbury Fox. As clinical evidence of its infectiousness are the facts that it so frequently occurs in epidemics; that in many instances the mother, the nurse, or other members of the family have been attacked; that epidemics in lying-in institutions have been almost unknown since the introduction of antiseptic methods, cases being now almost confined to isolated examples and to small epidemics of a mild type among the very poor. Successful experimental inoculations have also been recorded by Röser, Blomberg, Vidal, and others.

As to the manner in which the infection spreads, it cannot be by direct contact in infants of only a few days old, so that each case in an epidemic must arise from some common source. In the majority of outbreaks on record the actual source of infection has not been traced. Klüpfel (1875) gives an instance in which a one-year-old child

had an eruption of clear serum-filled bullæ after measles. The infection passed to a new-born baby, which died three days later. Afterwards other members of the family developed bullæ, and two sisters "ordinary impetigo." Krimm 1893 also records the case of a new-born infant dying with a bullous eruption where a 1½-year-old brother was also affected. Previously to the birth of the child an elder sister had had a bullous eruption of the face. Bronsin 1899 mentions an epidemic in the practice of a midwife in which, between August 11th and October 10th, she attended nine births. All the children had Pemphigus neonatorum, and two died. In the middle of September and in October she herself had bullæ on the fingers. In an epidemic which came under the writer's observation, in which there were four cases of Pemphigus neonatorum, the infants all recovering, the infection was traced to the midwife who attended, and who was found to have a whitlow on the finger. In this instance two of the mothers had puerperal fever. In one of the families two other children afterwards had Impetigo contagiosa of the face. In none of the other epidemics recorded, however, does the infection appear to have been traced to any such definite origin, although it is frequently expressly stated that the cases were confined to the practice of one midwife.

The view that Pemphigus neonatorum is closely related to Impetigo contagiosa has been held by many writers—Faber (1890), Felsanthal (1891), Joseph (1895), Bahr (1896), Escherlich (1896), Hanck (1899), Bernstein (1899), Luithlen (1899),—and attention has from time to time been drawn to the occurrence of ordinary Impetigo in other members of the family. Instances of this have just been quoted above, and many others are recorded. Quite recently this relationship has been strongly insisted upon by Matzenauer.* The difference in the type of the lesions is accounted for by the difference of the anatomical and physiological conditions of the infantile skin. An objection to this view suggests itself in the fact that Pemphigus neonatorum, unlike Impetigo contagiosa, is frequently a fatal disease. Although in some epidemics the cases are all of a benign type, in others a certain number of infants die, while in others most of the children succumb. In some instances the fatal

* "On the Identity of Pemphigus neonatorum and Impetigo contagiosa," Matzenauer, *Wiener klinische Wochenschrift*, No. 47, 1900.

result may be explained by comparison with the effects of extensive superficial burns in infants, in which severe symptoms arise from a congestion of internal organs or from toxic absorption from an extensively denuded surface. In other fatal cases there are symptoms of acute septicæmia and corresponding changes; fatty degeneration of the liver and heart, congestion of the intestinal tract, etc., have been found post mortem; in these it is possible that systemic infection may have taken place either through the umbilical wound, or possibly by the mouth. In the frequently fatal cases which have been born with the eruption, infection has probably taken place through the placenta. In other cases the severity of the illness has been due to gangrenous or hæmorrhagic lesions, comparable to those of *Dermatitis gangrenosa* of older children, and probably arising from a secondary infection. Again, there may be subsequent furunculosis and even pyæmia as a result of secondary infection. In none of these instances, then, are the fatal results incompatible with the view that the disease is really an infantile form of *Impetigo contagiosa*.

It has been suggested that *Pemphigus neonatorum* may be related to recently described forms of Acute Pemphigus of an infective nature. There is undoubtedly a resemblance to the so-called Epidemic Pemphigus which sometimes attacks older children, but which is well recognised as an acute form of *Impetigo contagiosa*. In many epidemics of *Pemphigus neonatorum* adults and older children are attacked by lesions of a more markedly bullous character than the lesions of *Impetigo contagiosa*, and with less tendency to form amber crusts, yet in the same epidemic others may have typical *Impetigo* lesions.

Acute pemphigus of children, accompanied often by sickness, diarrhoea, and fever, and sometimes following on measles, scarlet fever, or other exanthem, is possibly also of the same nature. In Klüpfel's case of *Pemphigus neonatorum* quoted already, the infection sprang from a boy who had an acute pemphigus-like eruption after measles, and in this instance two other children had ordinary *Impetigo*. The Acute pemphigus of adults, although it bears a clinical resemblance to some of the more malignant forms of the *Pemphigus neonatorum*, has a distinct etiological factor in its animal origin, so strongly insisted upon by Pernet, which seems to put it in another category.

In many cases of *Pemphigus neonatorum* there is more or less desquamation. In Ritter's disease, *Pemphigus foliaceus neonatorum*, this is a marked feature, and many authorities hold that this affection is really a severe type of *Pemphigus neonatorum*. Ritter himself regarded it as of "septic" origin. The disease is rare, and in its typical form unknown in this country. Milder forms of exfoliation, sometimes preceded by more or less well-marked bullæ, have been described. Spencer, of Sydney, recorded an epidemic; a case has been published by Brand, and another by Whitfield. In Whitfield's case it was found "that the edges of the desquamating areas were in reality formed by the most flaccid of bullæ." These cases would seem to form a connecting link between the ordinary pemphigus forms and Ritter's disease.

Turning now to the bacteriology of the disease, one naturally finds that many observers have sought a causative micro-organism. Röser first described a "micrococcus" in 1876. Zeichmeister (1887) saw what he believed to be Demme's coccus. Strelitz (1890), by culture methods, isolated a milk-white and a golden yellow coccus, the latter corresponding closely to Demme's coccus of acute pemphigus of adults. Again, in 1893 Strelitz found a small number of a white and a much larger number of a yellow coccus, the latter indistinguishable from *Staphylococcus pyogenes aureus*; Almquist (1891) isolated a micro-organism closely allied to, if not identical with, *Staphylococcus pyogenes*; Peter (1896) found staphylococcus and a diplococcus like Demme's coccus in the contents of the bullæ in an infant, and also in the milk of the mother; Sollman (1898) found staphylococcus and a diplococcus, and a bacillus like the influenza bacillus; Kochler (1899) *Staphylococcus pyogenes* and a diplococcus; Bloch (1900) *Staphylococcus* and a streptococcus; Matzenauer (1900) *Staphylococcus pyogenes*. It will be noted that two observers thought that they saw the coccus of Demme which has been isolated by Bulloch and others from cases of Acute Pemphigus of adults; but their findings cannot be said to lend much support to the view that there is a relationship between *Pemphigus neonatorum* and this affection. Zeichmeister's observation was from microscopical appearances alone; and Strelitz, who in 1890 described a golden yellow coccus resembling in many respects the coccus of Demme, again found the same coccus in 1893, and considered it indistinguishable from the *Staphylococcus pyogenes aureus*. Most

observers have found the *Staphylococcus pyogenes aureus*, and have regarded this as the specific micro-organism of the disease; but the recent researches of Balzer and Griffon, of Kaufmann and of Sabouraud, throw doubt upon their conclusions, for they have clearly demonstrated that vesicular lesions are of streptococcic origin, while the lesions of staphylococcus are purulent.

Sabouraud has shown that the error in ascribing the lesions of the phlyctenular impetigo of Tilbury Fox to a staphylococcus instead of to a streptococcus has arisen from the using of culture methods unsuited for the purpose of isolating the micro-organisms of the skin. The *Staphylococcus pyogenes aureus*, which is invariably present in the impetigo lesions as a secondary infection, grows so freely on the ordinary gelatine media that the more slowly growing streptococcus is altogether swamped by it. Sabouraud obtained pure cultures of a streptococcus (streptococcus of Fehleisen) by using a fluid medium, either broth or, preferably, ascitic fluid in a sterilised capillary pipette (in order to obtain anaërobic conditions), and incubated at 37° C.* By Sabouraud's method in a case of *Pemphigus neonatorum*, Whitfield† obtained pure cultures of the streptococcus, and MacLeod‡ had a similar result.

In future, therefore, in the study of the bacteriology of *Pemphigus neonatorum* it will be necessary to make use of a similar technique. The clinical evidence of the relationship of this affection with impetigo renders it probable that here also in the majority of cases a streptococcus will be found, either the *Streptococcus pyogenes* or an allied form. The *Staphylococcus pyogenes aureus*, which is responsible for the subsequent pustulation of the contents of the lesions which are at first clear, and also for an occasional furunculosis, is, as in the case of *Impetigo contagiosa*, invariably present, but only as a secondary infection.

The conclusions may be summarised as follows:

1. It is now generally admitted (*a*) that *Pemphigus neonatorum* is an infantile form of *Impetigo contagiosa* of Tilbury Fox; (*b*) that the phlyctenular *Impetigo* is due to a streptococcic infection.

* For details of the technique recommended by Sabouraud see *Ann. de Derm. et de Syph.*, tome i, No. 3, March, 1900, p. 324, *et seq.*

† Whitfield, *Brit. Journ. Dermat.*, June, 1903, p. 221.

‡ MacLeod, Nov. 14th, 1903, p. 1278, *Brit. Med. Journ.*

2. It seems, therefore, reasonable to suppose that observers who have described the *Staphylococcus pyogenes aureus* as the infective agent in *Pemphigus neonatorum* have been concerned with a secondary infection, and that investigation by special culture methods will discover the *Streptococcus pyogenes* as the primary cause.

SOCIETY INTELLIGENCE.

DERMATOLOGICAL SOCIETY OF LONDON.

AN ordinary meeting of this Society was held on Wednesday, November 11th, 1903, at 5.15 p.m., Dr. T. COLCOTT FOX in the chair. The following cases and specimens were shown :

Dr. GRAHAM LITTLE showed (1) a case of *prurigo of Hebra* in a boy aged 10, who had had the disease only one year, and it had consequently developed for the first time at the age of nine, being thus an exception to the rule which both Hebra and Kaposi state—namely, that it commences within the first year of infancy. The present case was a very typical one in appearance and distribution, and there was no dissent from the diagnosis offered. The eruption was nearly universal and was very itchy, and the glands in the neck, the groin, and axilla were all markedly enlarged. The boy was small and ill-developed for his age. There are other children in the family, but no other members are affected in this way.

(2) A case of *Dermatitis herpetiformis* during pregnancy in a woman aged 28. She had had a similar eruption with the previous pregnancy, the rash having then appeared three days after delivery. In the present attack she had been pregnant six months before it came out. The bullæ were very large, some on the arm, for instance, being at least an inch and a half long by about half an inch across. The present eruption had commenced on the feet, and when shown she had vesicles and bullæ on the feet, arms, forearms, and abdomen. Some of the vesicles seemed to come out on healthy skin without any inflammatory areola, but in the majority there was a certain amount of redness of the surrounding skin either before or during the develop-

ment of the bullæ. In the case of the abdomen there was considerable erythema, both before and after the appearance of the vesicles, which were grouped in this position in a typically herpetiform manner. The patient complained of intense itching throughout, and her sleep was disturbed by this symptom, so that she appeared worn and ill. There was no lesion of the buccal mucous membrane. The eruption had been observed for three weeks, and seemed to be increasing. A culture taken from one of the unbroken vesicles had remained sterile after a week of incubation at 37° C.

Dr. COLCOTT FOX remarked that if this case was not to be included in the term "pemphigus," it was difficult to see what diseases remained to be classed under that term.

(3) A case of *Lichenoid syphilide* in a girl aged 17. All history of infection was denied, but the hymen was not intact, and there was a typical mucous papule in the fold of the vulva and thigh. The eruption had lasted five months according to the account obtained, and it had not been apparently treated. Its distribution and appearance were as follows:—It is nearly entirely homogeneous, consisting of small papules obviously seated round the pilo-sebaceous orifice, in some cases hardly at all raised, in others sharply acuminate and quite horny. The resemblance to the papules of *Lichen planus* was extraordinarily close. The papules were arranged in nummular groups of ten or more, and were particularly firm and red and acuminate over the buttocks, where the groups were also most thickly distributed. Similar but smaller groups were to be seen on the front of the wrist, on the chest, the arms, the legs, the thighs, and abdomen. On the shoulders there were three or four lesions of a different type; these were flat pink rings, not made up of follicular papules, and about the size of a threepenny bit—a ringed syphilide, in point of fact. On the face about the mouth there were three or four flat circinate patches of a papulo-squamous type. The fauces were congested, and a doubtful-looking lesion like a mucous patch was observed on the tonsil. The eruption was slightly itchy. The patient looked ill and white. There was general glandular enlargement, the inguinal, cervical, and occipital glands being especially noticeable.

Dr. J. M. H. MACLEOD exhibited a case of *grouped and inflamed comedones* in an infant aged 11 months. The patient was a healthy,

well-nourished little boy, who had suffered from the eruption since he was seven months of age, and had been under observation at the Victoria Hospital for Children for three weeks. The eruption was most marked on the front of the chest, and extended down symmetrically from the neck to an almost straight line across the chest, about an inch below the level of the nipples. From there it spread over the shoulders on to the arms, as far down as the lower borders of the axillæ, and round to the upper part of the back, above the level of the spines of the scapulæ. The eruption consisted of grouped comedones, many of which were inflamed. Associated with them were numerous small milium-like bodies, whitish yellow in tinge, and about the size of a pin's head. Many of these had a central punctum or depression, and when squeezed a bead of cheesy sebaceous material was extruded; they were evidently small retention cysts of the sebaceous glands. Besides these there was a number of lesions of a more advanced acneiform type, which were more inflamed and had a purulent yellow centre. These varied in size from a hemp-seed to a split pea. There were also numerous small yellowish crusts or scales, resulting from the drying up of the acneiform lesions, which when they came away left small atrophic macules or pits. The eruption had commenced on the back and spread from there over the shoulders on to the chest, and on the back it consisted almost entirely of small pits and atrophic red shiny macules. The sequence of events in the evolution of the lesions appeared to be a comedo, a retention cyst of the sebaceous gland, and inflammation and transformation of this cyst into a purulent acneiform lesion, the drying up of the pustule to form a crust, the falling off of the crust, and the production of a pitted scar. The eruption was itchy, and was complicated by a few excoriations from scratching. The rest of the infant's skin seemed to be healthy, and there were no comedones present in the more usual situation on the forehead. The patient was an only child, and there was no history of skin disease in the parents.

As it has been suggested frequently that such cases are the result of some local irritant, a careful inquiry was made in this connection, but with negative results. There was no history of the application of any local irritant to the affected part, such as turpentine, olive oil, plasters, or poultices, and in place of flannel a small linen garment was worn next the skin.

The exhibitor considered that the eruption was far more readily

explained as due to a local infective process of a parasitic nature than as the result of local applications, and hoped to report a bacteriological examination on the case at a later date. Another point of interest in the case was the fact that it occurred in a male infant, since the large majority of cases reported have been in males. This, he considered, was more than a coincidence, and suggested that anatomical considerations such as larger pilo-sebaceous follicles might be a factor, not only in determining the sex, but in causing the selection of the regions generally affected.

Dr. COLCOTT FOX, who was the first to describe this peculiar condition, expressed his opinion that the present eruption belonged to the same category as the grouped comedones of the foreheads of infants and young children, and was inclined to regard it as an infective process.

Dr. WHITFIELD remarked that he had examined a case bacteriologically with negative results, and

Dr. GRAHAM LITTLE referred to the case which he had exhibited to the Society.

Dr. SEQUEIRA showed (1) a woman suffering from *multiple rodent ulcers* of the face. A special point of interest was the rapid development of some of the ulcers. A full account of the case will be published in this Journal at an early date.

(2) A man aged 58, suffering from *Lichen planus* of the annular type. The patient had first noticed the eruption fifteen months ago, when purplish-red spots developed on the forearms. The spots itched a great deal, and fresh lesions appeared in the site of scratches. There was a definite history of syphilis forty years ago, and of several attacks of gout. The eruption was present upon the extensor surface of both forearms, and on the front of each wrist. There were also a few isolated spots below the knees. On the front of the wrists there were plane papules arranged in lines, apparently occurring where there had been scratches. Elsewhere the spots were about one third of an inch in diameter, and these had definitely increased by centrifugal enlargement while the patient had been under observation. Some of these spots showed slight but definite atrophy in the centre of the areas. The case had proved very resistant to treatment.

(3) The girl with *ulcers of the leg* shown at the last meeting. With rest in bed, and weak antiseptic lotions, the ulcers had almost entirely healed.

Dr. WHITFIELD showed a case of *pseudo-leukæmic prurigo*, details of which, it is hoped, will be reported later.

Mr. ARTHUR SHILLITOE also showed a case of *psoriasis* which had exhibited marked peculiarities when first seen, but the eruption had so altered before the meeting of the Society that Mr. Shillitoe considered a detailed report of the case unnecessary.

DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, October 28th, 1903, Dr. STOWERS in the chair.

The PRESIDENT made a sympathetic reference to the loss the Society had sustained in the death of Sir George Duffey, a Vice-president and an Original Member of the Society. He also announced that Dr. Edward Stainer had been chosen to fill the vacancy caused by the resignation of Dr. Wilfrid B. Warde of the post of Jun. Hon. Sec.; that Mr. Spencer Hurlbutt had been appointed to the post of Clinical Secretary; and that Dr. Chas. Samson Jaffé had been unanimously elected a Member of the Society.

The following cases were exhibited :

Dr. ABRAHAM showed (1) a case of *Xanthoma diabeticorum* in a man aged 38. The change in his skin he first noticed two years ago. The extensor surfaces of both knees and elbows are occupied by groups of discrete firm papules, yellowish in colour, and surrounded by faint red areolæ, of a size varying from a pin's head to that of a large pea; the appearance of the lesions, especially on the tops of the elbows, being at first sight very similar to a collection of pustules. Numerous papules are also distributed over the sacrum and buttock.

The lines of flexure on both palmar surfaces of hands and fingers show narrow, flattened, ribbon-like streaks of xanthoma, a condition more usually seen in cases of *Xanthoma multiplex*.

The eyelids and other parts of the body are free from signs of the disease. There are no subjective symptoms. His urine when first examined had a specific gravity of 1027 and contained a trace of sugar.

Under the effects of dieting he lost over a stone in weight and his

urine became free from sugar, without, however, having much effect on the skin trouble.

(2) A case of *sclerodermia* in a young married woman. The affection commenced about six months ago with extreme pain, tenderness, and a red swelling in the right leg. She was then about two months pregnant, and shortly before had received a blow on the leg.

On admission, about two months ago, there was found to be present a hard, board-like, depressed band of sclerodermia with a distinct roseate border, extremely painful, and rendering her quite lame. The lesion extended from the inner ankle up the back of the calf, and on the inner side of thigh, following the course of the internal saphena vein to Scarpa's triangle.

Under the Röntgen rays, applied twice a week, she has distinctly improved and has quite lost the pain. The affected area is smaller and the sclerosed part softer.

Dr. GRAHAM LITTLE showed (1) a case of *epithelioma* which had developed in the site of a *nævus* on the forehead of a woman whose present age was 65. The *nævus* was congenital; fifteen years ago it had become irritable, and slowly grew larger and more prominent; within the last four months it had shown a tendency to bleed readily and freely. At the present time there is a raised spongy-looking growth, not of the rodent-ulcer type, for there is no excavation or raised hard edge, and it is much more vascular than rodent ulcer usually is. Around the growth the skin is somewhat red, but this is to be attributed to the application of ointments, etc., to the sore, since the redness has perceptibly decreased while under observation. The case is interesting as an instance of malignant disease appearing in the site of a *nævus*. The tumour is to be excised, as the patient lives in the country and cannot attend for the light treatment, which might possibly be the better alternative from the point of view of the cosmetic effect; it will be possible, therefore, to obtain sections of the growth, and these will be shown at a later meeting.

(2) A case of *symmetrical gangrene* of the auricles in a young man aged 22 years. He is a native of Jersey, and seems in delicate health, suffering much from chilblains and weak eyes. The latter were examined in the ophthalmic department of St. Mary's Hospital, and the report is as follows:

“ Corneal nebulæ, with denser spots of old ulceration in both eyes; also secondary iritis in right eye. The condition is due to old phlyctenular keratitis, pointing to a tubercular rather than to a syphilitic origin.”

The depressed bridge of the nose, and the teeth, which are small, ill-formed, and widely separated, as well as slightly notched, convey the impression of congenital syphilis, but the ophthalmic report indicates tuberculosis rather than syphilis. The gangrene commenced two years ago and has been slowly continuous since then, resulting in the loss of considerable portions of the cartilage of both ears; the process is still continuing in the lower part of the auricle, where there is a hard scab and chronic ulceration. The hands show no signs of Raynaud's disease; there has been no numbness, or pallor alternating with lividity, of the fingers. The diagnosis of Raynaud's disease seems, therefore, negatived, and the alternatives seem to lie between tuberculosis and congenital syphilis. Gangrene of the auricles has been recorded in the case of congenital syphilis, but usually occurs earlier in life. The condition of the eyes, on the other hand, is confirmatory of the diagnosis of tubercular ulceration, and this seems the most probable diagnosis, the case being perhaps one of “lupus-vernio” of Besnier and Hutchinson, the symmetry being explicable by the preliminary chilblains of the ears. There is no history of frost-bite, and the mild climate of Jersey renders this improbable.

(3) *A case of Elephantiasis* in a man aged 45. The left leg and thigh are alone affected, and are enlarged to two or three times the natural size. The skin is of brawny hardness, and is fissured in places. The swelling begins above the foot and increases upwards to the line of Poupart's ligament. The scrotum is not swollen at all. On the left leg there are numerous pigmented scars suggestive of past syphilis, but he denies all history, except that he suffers from sore throat. The condition has lasted for eight years; he has never been out of England, and has not had erysipelas or a severe wound of any kind except an injury to the left leg, which happened long before the swelling was noticed. He knocked the leg, which became sore, and he was treated for this for about two months. No other part of the body is affected. A diagnosis of elephantiasis consecutive to syphilis was ventured.

Dr. NORMAN MEACHEN showed a case of persistent *purpura*, which occurred in Dr. Abraham's clinique at the West London Hospital. The patient was a girl of 18. The rash appeared "all of a sudden one evening," on the legs, four years ago. Since then it has persisted with varying intensity up to the present time. The thighs present a fine purpuric mottling, the lower part of the abdomen, the arms and fore-arms being also affected. She is not markedly anæmic, and her general health is good. It is stated that the rash is more abundant and brighter at the menstrual epochs. The menses are regular but somewhat scanty. The patient's father has had rheumatic fever three times, but the girl herself has had no other illnesses. The only subjective symptom complained of is a burning sensation in the areas affected.

The PRESIDENT showed a water-colour drawing of a case of *Peliosis rheumatica*, in which the distribution of purpuric spots on both legs was similar to Dr. Meachen's case.

The PRESIDENT said, it was an unusually marked case of the rare disease, *Peliosis rheumatica*, which he had recently seen in consultation with Dr. Sibley.

The patient, a female aged 38 years, had been in bed several weeks suffering acute articular pains in the shoulders, elbows, wrists, hips, knees, and ankles. During the last month a papular eruption, with characteristic subcutaneous hæmorrhagic extravasations, had developed over the whole body with remarkable symmetry. The papules were the first to appear, and these showed when the subsequent effusion occurred, as is seen in extreme instances, a tendency to grouping in clusters considerably raised from the surface. Coincidentally with these considerable constitutional disturbance existed, with elevation of temperature, rapid pulse, furred tongue, etc. The patient had a cardiac systolic apical murmur, and the urine was alkaline in reaction, sp. gr. 1015, but without albumen or sugar. The other organs were healthy. The case was now making satisfactory progress towards recovery, and the extravasations were gradually undergoing the colour changes characteristic of blood-stained skin when absorption is taking place. The coloured drawing will be added to the Society's album.

Mr. GEORGE PERNET showed (1) a male private patient, who came originally under observation for a very obstinate thickened patch of *lichenification* on the inner side of the right thigh and in contact with the scrotum. It eventually cleared up entirely under persevering treatment, but the area now presented a marked growth of strong and curly hair, whereas the corresponding area on the other thigh was quite smooth and hairless. It was for the secondary *hirsuties* that Mr. Pernet brought forward the case.

(2) A young woman aged 19 with *Lupus erythematosus disseminatus*,

who first came under observation in Dr. Radcliffe-Crocker's clinique at University College Hospital in January, 1902, when the following notes were made:—The disease began on the fingers, which had been affected for the last three winters, the patient putting it down to chilblains. The terminal phalanges were all affected, except the right middle finger, presenting purplish-red convex swellings, slightly tender, but which did not itch very much. On both index fingers the other phalanges were also affected, the lesions being slightly scaly. There were similar lesions over the knuckles and along the ulnar border of the right hand. There were also lesions of the same kind on the palmar surface of some of the fingers. The hands had been affected since October, 1901, the previous crop having cleared up in May of that year. The hands were cold, but scarcely at all moist. In 1902 the face was affected for the first time. There were lesions—mostly $\frac{1}{8}$ in. in diameter, a few $\frac{1}{4}$ in., and one in front of the left ear $\frac{1}{2}$ in. by $\frac{1}{4}$ in.—about the mouth, orbits, above and below end of the nose, the border of the hair, inside the concha of the right ear, and on the rim of the left. Some were slightly depressed in the centre, and were very slightly scaly. The lymphatic glands of the left side of neck were enlarged, and could be felt down to the clavicle. On the right side they were barely perceptible. The mother's step-brother died of phthisis. The patient used to have chilblains on the feet, but this had not occurred for the last three years. The thyroid was prominent and enlarged; pulse 120; but no bulging of the eyes could be said to be present. The patient improved very much under treatment. A few fresh small lesions appeared along the ramus of the lower jaw about the end of June, 1902. On October 27th, 1903, she came with a fresh outbreak, this time affecting the chest and arms as well as the face and neck. This had been going on for two months. The lesions on the chest were in the form of papules, and also in small patches, the largest $\frac{1}{4}$ in. in diameter. On the extensor aspects of both upper limbs there was marked hyperæmia of the follicles generally, and numerous hemp-seed to $\frac{1}{4}$ in. purplish-red patches, slightly scaly. They were sparse on the forearms, and there were also a few on the backs of the hands. The flexor aspects were almost free. The patches on the face and neck were numerous, but were more erythematous than scaly. The rash was very irritable, which accounted for the prominent follicles about the arms. The urine was acid, of 1030 sp. gr., and con-

tained neither albumen nor sugar. There was a little redness about the palate.

In the discussion which ensued, in which Drs. BOWLES, STAINER, GRAHAM LITTLE, and others took part, it was pointed out that individual lesions, especially seen on the upper part of the trunk and side of neck, were in many instances indistinguishable from those of *Lichen planus*, and in corroboration of this diagnosis there were lesions of like character on the mucous membrane of the mouth.

Mr. PERNET could not agree with those members who considered the case was one of *Lichen planus*. Some of the involuting papules on the chest were *Lichen planus*-like, but this appearance was seen in various conditions. Mr. Pernet pointed out the atrophic areas about the face and hands, the seat of old lesions. The case was an interesting one from several points of view.

Dr. RUTHERFORD showed a case of *Lichen planus*. The patient, a man aged 59, stated that the eruption first appeared two and a half years previously. On the flexor surface of both forearms were numerous typical, flat, shiny, discrete papules. There was also a symmetrical distribution of the disease on the extensor surfaces of the legs, where the lesions had become grouped into rings and patches of a deep red colour, well raised above level of surrounding skin, and varying in size from a sixpenny piece to a florin. The general appearance of the rash in this part, the colour and contour of the lesions, gave rise to a suspicion of a syphilitic origin, but no history of his having contracted the disease was obtainable. A few discrete whitish macules were to be seen on the mucous membrane of the mouth. The subjective symptoms were so slight as to cause him no inconvenience.

Dr. T. D. SAVILL exhibited a case of *hypertrophic scarring* after smallpox in a woman aged 37. The patient had had confluent smallpox eighteen months before, and now the face was almost covered with minute irregular scars, between which the remaining skin, protruding by reason of hypertrophy, produced an appearance of wart-like elevations. The case had resisted treatment so far, and surgical measures were suggested.

Mr. ARTHUR SHILLITOE showed a case for diagnosis, a married woman with symmetrical squamous patches on the palms of hands, etc. Four years ago her husband was removed to a lunatic asylum, very

shortly after which she states that her throat was ulcerated severely. Two years ago she attended Mr. Charles Gibbs's out-patients' at the Lock for (?) a papulo-squamous syphilide affecting the palms of the hands; the nails of the feet were also implicated. The condition has not improved under antisyphilitic treatment.

The PRESIDENT thought the condition of the hands was perhaps a local dermatitis set up by her occupation—that of a barmaid.

Mr. PERNET was inclined to consider the case as one of pus-inoculation, and not syphilitic.

The PRESIDENT exhibited the following cases:

1. Female, aged 45 years, who was the subject of primary *syphilis* over twenty years ago, and who had recently developed several severe tertiary ulcers about the forehead and nose. During the last three months extensive ulceration had occurred in front of the angle of the lower jaw, extending towards the mouth. The position was unusual, and the appearance was not incompatible with malignant disease, but the diagnosis was unquestioned, and improvement had already commenced with antisyphilitic remedies.

2. Female, aged 69 years, who had recently undergone a successful removal of a *rodent ulcer* situated upon and below the left lower eyelid. The transplanted skin had become firmly attached, and the healing was complete.

3. Female, aged 38 years, with well-marked *Lupus erythematosus* involving the forehead, nose, cheeks, and right ear. The disease was somewhat rapid in its onset, and had not previously occurred. The remainder of the body and mucous membranes were unaffected.

4. Female, aged 47 years, who had *dermato-syphilis* two years ago, and who was now the subject of tertiary disease upon the apex and alæ of the nose. The deposit was of superficial character, and as yet had not developed the characteristic tubercular nodules, so that a striking resemblance to *Lupus erythematosus* existed, so much so that it had already been mistaken for that disease. There was no doubt, however, as to the diagnosis, and that appropriate treatment would soon remove the malady.

Dr. WILFRID WARDE showed a case of extensive *hypertrophic scarring* following *typhoid fever*. A male, aged 17, sought relief for a serous impetigo of the face, which rapidly yielded to treatment. Four years

previously he had suffered from typhoid, in the course of which he developed an inflammation of the lungs and a scar-leaving eruption. He now has a great number of white scars scattered over the trunk and extremities. They are very abundant on the front of the chest, between the shoulders, and in lumbar and sacral region. Here they are mostly large, and round or oval. Some are raised and smooth. Some present a cribriform appearance, and some are much depressed below the surrounding surface. On the thighs the scars are very numerous and smaller. Most are round, but many linear. A great number project considerably above the surface. It is interesting to note that a very large hypertrophic scar exists on the front of and to the right of the sternum. This is attributed to a hot poultice. At the April meeting the exhibitor showed for Mr. Waren Tay a man with a punched-out ulcer of the leg following typhoid fever.

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INDEX OF CONTENTS.

- | | |
|--|--|
| <p>Acne agminata (Crocker), 292
 „ keloid (Whitfield), 413
 „ varioliformis (?), with Raynaud's disease (Warde), 299
 „ vulgaris, etiology of (abstr.), 262
 Acrodermatitis chronica atrophicans (abstr.), 76, (abstr.) 334
 Actinomycosis (Evans), 250
 „ cutaneous, of finger (abstr.), 419
 Adenoma of sweat-gland (abstr.), 215
 Alopecia areata (MacLeod) 65, (Meachen) 176, (abstr.) 268
 „ „ etiology of (abstr.), 193
 „ „ influence of light on (abstr.), 228
 „ „ neurotica (Sequeira), 135
 „ congenita familiaris (abstr.), 417
 Angiokeratoma, with Erythema pernio and Bazin's disease (Dore), 323
 Anthrax of the skin (abstr.), 226
 Anthropoid apes, experimental researches on (abstr.), 421
 Aplasia of cutis and subcutis (abstr.), 416
 Arsenic, erythematous keratoderma from (White), 21
 Arsenical eruption and intoxication (abstr.), 74
 Asphyxia reticularis multiplex (Little), 209
 Atoxyl, further experiments with (abstr.), 306
 Aureol, skin affections following use of (abstr.), 74</p> | <p>Bazin's disease, with angiokeratoma, etc. (Dore), 323
 Becquerel rays, action on skin (abstr.), 333
 Blastomycosis (Sequeira), 121
 „ systemic (abstr.), 263
 „ “Blastomykose, die” (A. Buschke), review of, 71
 Botryomycoma, Is there a? (abstr.), 341
 Bullous eruption (Penrose), 184, (Little) 145
 „ „ vegetating (Ormerod), 26
 Calcification of the skin (abstr.), 223
 Callosities, symmetrical linear (Warde), 178
 Canities (Little), 97
 Chromidrosis, black, with hysterical paralysis, (abstr.), 376
 Coffee, cutaneous reaction to (abstr.), 301
 Colloid degeneration in scars (abstr.), 39, (abstr.) 223
 Colloid degeneration of the skin (abstr.), 39
 Comedones, grouped, in infant (Little), 253, (MacLeod) 453
 Crusts, histogenesis of (abstr.), 183
 Dermatitis artefacta (Crocker), 99
 „ coccidioides (abstr.), 184
 „ follicularis et perifollicularis conglobata (abstr.), 306
 „ herpetiformis (Galloway), 24
 „ (Pringle) 211, (Little) 409
 „ hiemalis (Eddowes), 33</p> |
|--|--|

- Dermatitis, malignant papillary** (Stowers), 213
 „ **papillaris capillitii** (Meachen), 177
 „ **psoriasiformis nodularis** (abstr.), 221
 „ **toxica from Rhus vernicifera** (abstr.), 190
Dermatological Congress, Fifth International, subjects for discussion, 160
Dermatological Society of Great Britain and Ireland, 32, 102, 141, 172, 215, 256, 295, 456
 „ „ **of London**, 24, 63, 95, 129, 169, 206, 250, 287, 407, 452
Dermatoses due to vermin (abstr.), 79
 „ **due to X-rays** (abstr.), 196
Dermatosis, follicular (Abraham), 215
Dermochromes, portfolio of, review of, 327
Diagnosis, cases for (Whitfield), 101, (Meachen) 105, (Pearson) 132, (Weber) 138, (Abraham) 142, 215, (Eddowes) 172, (Shillitoe) 217, (Little) 254, (Mackey) 410, (Shillitoe) 461
“ Dictionary, American Illustrated Medical,” review of, 72
“ Diseases of the Skin ” (J. V. Shoemaker), review of, 72
 „ „ (H. Radcliffe-Crocker), review of, 109
 „ „ **A treatise on** (H.W. Stelwagon), review of, 70
Dyskeratoses, congenital (abstr.), 378
Ecthyma terebrans (Jamieson and Huie), 391
Eczema (Dore) 407, (Little) 410
 „ **recurring, on exposed parts** (Warde), 349
 „ **seborrhoeic** (Little), 175
Eczema, seborrhoeicum areatum (Little), 144
 „ **striatum medianum unguium** (abstr.), 414
Elephantiasis (Little), 458
 „ **lymphangiectatica congenita** (abstr.), 382
Epidermis and connective tissue, biological relation of (MacLeod), 262
Epidermolysis bullosa hereditaria (abstr.), 149
Epithelioma (Little), 457
Eruption, peculiar symmetrical (Whitfield), 138
Erysipelas-like dermatitis due to Fränkel's pneumococcus (abstr.), 192
Erythema bullosum (Galloway), 207.
 „ **chronic purpuric, with enlargement of liver and spleen** (abstr.), 374
 „ **marginatum perstans** (abstr.), 375
 „ **multiforme** (Galloway), 207, (Stowers) 213
 „ „ **anomalous case of, with cardiac and renal disease** (Whitfield), 273
 „ „ **and Lupus erythematosus: their relation to general toxæmia** (Galloway and MacLeod), 81
 „ **pernio, a tubercular exanthem?** (abstr.), 376
 „ „ **with angiokeratoma and Bazin's disease** (Dore), 323
 „ „ **with vesication** (Savill), 177
 „ **scarlatiniforme desquamativum recidivans** (abstr.), 337
Erythemata as indicators of disease (Galloway), 235
Erythème fluxionnaire et persistant (abstr.), 340

- Erythrodermie pityriasique en plaques disseminées (abstr.), 329
- Exfoliative dermatitis, four forms of general (abstr.), 150
- Exophthalmic goitre, dermatoses in (abstr.), 375
- Favus, of scrotum with ringworm of thigh (abstr.), 186
- „ recovery with izar (abstr.), 153
- Finsen light, histological changes in Lupus vulgaris treated by (abstr.), 222
- „ „ treatment of lupus (abstr.), 332
- Follicular eruption (Pringle), 31
- Folliculo-adenitis, streptogenic necrogenic (Eddowes), 173
- Furuncle, treatment of (abstr.), 268
- Gangrene, symmetrical (Little), 457
- Gangrenes of skin, multiple initial (abstr.), 79
- Gonococchæmic eruption (?) (Fox), 251
- Granuloma of cheek (Pringle), 211, 290
- „ trichophyticum Majocchi (abstr.), 73
- Granulosis rubra nasi (Jadassohn) (MacLeod), 131, 197
- Green scales, inflammatory condition with (abstr.), 156
- Hæmangendothelioma cutis papulosum (abstr.), 39
- Hair discs (abstr.), 75
- „ growth of, influence of light on (abstr.), 228
- „ system in man (abstr.), 380
- Hairs, papillary, easily pulled out (abstr.), 153
- Hemiatrophy of face (Savill), 107
- Herpes of left upper division of fifth nerve with ocular paralysis (Hall), 311
- „ zoster (Galloway), 24, (Pernet) 146, (Warde) 298
- „ „ with general herpetic eruption (Galloway), 24, (abstr.) 151
- Hidrocystoma, study of (abstr.), 380
- “High Frequency Currents in the Treatment of some Diseases” (Chisholm Williams), review of, 329
- Hydroa herpetiforme (Pringle), 28
- Hyperidrosis, general (abstr.), 113
- „ in general paralysis (abstr.), 303
- „ local (Meachen), 104
- Ichthyosis (Abraham), 142
- „ foetal, relation to common form (abstr.), 270
- „ linearis (Evans), 408
- Induration after Phlegmasia dolens (Sequeira), 412
- Iron light, researches with (abstr.), 307
- „ arc light and carbon light (abstr.), 308
- “Journal of Cutaneous Diseases, The,” 68
- Keloid, spontaneous, and scar (abstr.), 156
- Keratoderma, acute erythematous, due to arsenic (White), 21
- Keratoma palmare et plantare (Whitfield), 255
- Keratosis of palms and soles (abstr.), 377
- „ pilaris, histology of (abstr.), 266
- „ universalis congenita (abstr.), 76
- Labiomycosis (Evans), 319
- Leprosy (abstr.), 339
- Lichen planus (Little), 95, (Eddowes) 102, (Shillitoe) 108, (Warde) 178, (Rutherford), 461
- „ „ annular type (Whitfield), 294 (Sequeira), 455
- „ „ anomalous case of (Whitfield), 294
- „ „ linear (Little), 25
- „ „ with scabies, lichenification of scratches (abstr.), 378

- Lichen ruber** (Galloway), 252
 „ „ **acuminatus** (abstr.), 307
 „ „ **moniliformis** (abstr.), 38
 „ „ **planus**, initial stages of (abstr.), 38
 „ **scrofulosorum** (Little), 209, (abstr.) 415
 „ **variegatus** (Freeman), 206
Lichenification (Pernet), 459
 „ of scratch-marks of scabies (abstr.), 378
Lichenoid eruption (Pringle), 291
Light treatment, 182, 222, 228, 263, 303, 307, 308, 418
Linear eruption on face (Sequeira), 211
 „ eruptions (abstr.), 155
Lipomata, multiple (Shillitoe), 177, (Rutherford) 298
Lupus érythématoïde (Leloir) (MacLeod), 25
Lupus erythematosus (Little), 175, (Fox) 251, (Adamson) 287, (Crocker) 292, (Morris) 410, 411, (Pernet) 459, (Stowers) 462
 „ „ **erythema multiforme**, relationship to general toxæmia (Galloway and MacLeod), 81
 „ „ in sisters (Sequeira), 171
 „ „ light treatment of (abstr.), 303
 „ „ **nodularis** (Pringle), 98
 „ „ **sclerodermic type** (Warde), 277
 „ „ some illustrative cases (Warde), 161
 „ „ unusual type and location (abstr.), 77
Lupus erythematosus with angiokeratoma and Bazin's disease (Dore), 169
 „ light treatment of (abstr.), 263
 „ treated by Lang's hot-air method (abstr.), 159
 „ **vulgaris** (Pernet), 105, (Warde) 108
 „ „ a year's experience of light treatment (abstr.), 418
 „ „ light treatment of, (abstr.), 263
 „ „ light treatment of, histological changes (abstr.), 222
 „ „ "The Combating of" (Finsen), review of, 182
Lymphadenoma, purpura in (abstr.), 187
Lymphatic leukæmia, acute, with subcutaneous nodules (abstr.), 303
Malignant neoplasms, reticular network in (abstr.), 224
 „ **"Medicine, Manual of"** (Monro), review of, 328
Melanoblasts in condylomata (abstr.), 382
Mercurial eruption, severe late-appearing bullous (abstr.), 152
Microsporon of scalp treated by X-rays (Whitfield), 66
Molluscum contagiosum (abstr.), 267, (Rutherford) 298
 „ „ in a syphilitic cured by mercury (abstr.), 387
Morphœa (Savill), 106
Mycosis fungoides (Stowers) 47, (Crocker) 65, (Stainer) 137, (Abraham) 295
 „ „ and its treatment by X-rays (Jamieson), 1
 „ „ cured by X-rays (Stainer), 212

- Nævi, histology of (abstr.), 383
 „ regional and linear (abstr.), 384
 Nævus question, on the (abstr.), 334
 „ unius lateris (MacLeod), 132,
 (Little) 169
 Nail diseases (abstr.), 414
- Paget's disease of nipple (Stowers), 213
 Parakeratosis variegata (Little), 34
 Parapsoriasis en gouttes (Little), 34
 "Pathology of the Skin, Handbook of
 the" (J. M. H. MacLeod), review
 of, 147
 Pemphigus, acute contagious, in the
 newly-born (Maguire), 427
 two cases in infants
 (Whitfield), 218
 „ foliaceous (Little), 209,
 (abstr.) 305
 „ neonatorum, in the light of
 recent research (Adam-
 son), 447
 „ vegetans (Ormerod), 26,
 (abstr.) 266
- Perforating ulcer (Little), 144
 Pharmaceutical notes (Skinner), 125
 "Photothérapie, La" (Chatin and Carle),
 review of, 426
 "Photothérapie et Photobiologie"
 (Leredde and Pautrier), review of,
 181
 Pigmented papular eruption (Eddowes),
 32
 Pilgrim's ulcer (abstr.), 193
 Pinta in Egypt, four cases of (abstr.), 40
 Pityriasis chronica lichenoides (abstr.),
 221
 „ rubra pilaris (Evans), 129
 „ „ „ in a child of
 four (Hall),
 403
- Porokeratosis, papillomatous, palmar
 and plantar (abstr.), 269
 Prurigo of Hebra (Little), 96
 „ pseudo-leukæmic (Crocker), 98
 Pseudo-leukæmic prurigo (Crocker), 98,
 (Whitfield), 456
 Pseudo-xanthoma elasticum (abstr.),
 223
 Psoriasis (Penrose), 289, (Shillitoe), 456
 „ and syphilis (Little), 210
- Psoriasis treated by copaiba (Shillitoe),
 412
 Purpura (Meachen), 459, arthritic
 (abstr.), 268
 Purpura in sarcoma, lymphadenoma,
 etc. (abstr.), 187
 Purpuras, the (abstr.), 340
 Purpuric eruption (Ewart), 63
 Pyodermatitis, linear serpiginous
 (abstr.), 78
- Quarterly Survey of Literature, 113, 229,
 343, 463
- Radiopraxis (abstr.), 304
 Radiotherapy, report on (abstr.), 389
 Raynaud's disease (Baumann), 288,
 (Warde) 299
 Reviews, 69, 109, 147, 181, 309, 325, 424
 Rhus vernicifera, dermatitis due to
 (abstr.), 190
 Ringworm of thigh, favus of scrotum
 with (abstr.), 186
 „ treated by X-rays (Whit-
 field), 67
- Rodent ulcer (Little), 169, (Stowers'),
 462, multiple (Sequeira),
 455
 „ treated by X-rays (Little),
 96
- Röntgen rays, pathological action of
 (MacLeod), 365
 "Röntgen rays in Therapeutics and
 Diagnosis" (Pusey and Caldwell),
 review of, 424
 Rupia (Shillitoe), 177
- Sarcoma idiopathicum multiplex pig-
 mentosum (abstr.), 225,
 (abstr.) 386
 „ idiopathicum multiplex pig-
 mentosum en plaques
 (abstr.), 267
 „ melanodes (Ormerod), 289
 „ multiple non-pigmented (Prin-
 gle), 134
 „ primary, of the skin (abstr.), 75
 „ purpura in (abstr.), 187
- Scales and crusts, histogenesis of (abstr.),
 183
 Scarring, hypertrophic (Savill), 461;
 following typhoid fever (Warde), 462

- Skin, colloid degeneration of (abstr.), 39
 abstr. 223
 " cribriform pitted Pernet, 255
 Sclerodactylia and scleroderma (Meachen, 116
 Scleroderma Stainer, 34, Little 1-3,
 (Savill 106, Meachen 116, abstr.)
 159, (Abraham) 457
 Sebaceous cysts, infection from Ed-
 dowes, 143
 " " multiple (Pringle, 292
 Seborrhoeic eczema (Little), 175
 Seborrhoeide of the face (Little, 252
 " " a rare (Pringle, 41
 Seborrhoides (Pringle, 30, (Roberts, 313
 Septicæmia, purpura in (abstr.), 157
 Skin, colloid degeneration of (abstr.), 39
 "Skin, a Treatise on Diseases of the"
 (H. W. Stelwagon', review of, 70
 " Diseases of the" (J. V. Shoe-
 maker), re-
 view of, 72
 " " (H. Radcliffe-
 Crocker),
 review of,
 109
 " Handbook of the Pathology of
 the" (J. M. H. MacLeod), review
 of, 147
 Smallpox, present epidemic in United
 States, 256
 " secondary eruptions in
 (abstr.), 330
 " some observations on
 (Roberts), 313
 Syphilide, annular and gyrate (Pernet),
 170
 " erythematous (Shillitoe), 100
 " framboesiod (Pringle), 97
 " gyrate (Shillitoe), 146
 " hypertrophic (Whitfield), 140
 " large papular (Shillitoe), 136
 " lichenoid (Little), 453
 " nodose, with phlebitis (abstr.),
 227
 " papular (Pringle), 31
 " varioliform (Shillitoe), 107
 Syphilis (Sequeira, 100, Fox 13),
 (Galloway 305, Shillitoe
 296, Stowers 462
 " anatomopatholog. character-
 istics of (abstr.), 271
 " and wounds (abstr.), 159
 " bacilli of (abstr.), 336
 " colloidal mercury in (abstr.),
 343
 " endemic and hereditary, in
 Asia Minor, v. Düring Pas-
 cha (Ogilvie, 11
 " hereditary (abstr.), 337
 " " early, without ex-
 anthem (abstr.),
 332
 " injection of biniodide of mer-
 cury in (abstr.), 271
 " "Intra-mercurial Injection in"
 (Lévy-Bing', review of, 309
 " intra-venous injection of mer-
 cury in (abstr.), 195
 " miliaires péripilaires (abstr.),
 423
 " recurrent node in (Shillitoe',
 34
 " secondary (Little, 170
 " " with nervous sym-
 ptoms (abstr.),
 269
 " tertiary (Little), 406
 " transmission of (abstr.), 336
 " with psoriasis (Little, 210
 Syphilomata of tongue and lip (Shilli-
 toe), 146
 Syphilonychia ulcerosa unguium heredi-
 taria (abstr.), 334
 Sweat-gland, widely spread adenoma of,
 with cystic formation (abstr.), 265
 "Therapeutik für Venerische u. Haut-
 kranke," Lang's (Ed. Deutsch.), re-
 view of, 112
 Tinea circinata, epicarin in (abstr.), 422
 " favosa capitis treated by izar
 (abstr.), 153
 " imbricata (Savill', 145
 " tonsurans, epicarin in (abstr.), 422
 " " in adult (Abraham),
 141
 " unguium (Pernet), 106

- Toxi-tuberculides (Little), 297
 "Transactions of American Dermatological Association," reviews of, 69, 325
 Trichohyalin (abstr.), 414
 Trichomycosis capillitii (abstr.), 388
 Tubercle, purpura in (abstr.), 187
 Tubercular folliculitis (Hartigan), 104
 " perifolliculitis (Hartigan), 174
 Tuberculide, acneiform (abstr.), 190
 Tuberculides (Little), 95, 103, (Rutherford) 297
 " multiple (Whitfield), 214
 Tuberculosis of skin, clinical observations on (abstr.), 191
 Tuberculous eruption (Sequeira), 136
 Turpentine eruption (Warde), 37
- Ulcer, chronic, in an infant (Little), 176
 " of leg (Warde), 178, 218
 " perforating (Little), 144
 " Pilgrim's (abstr.), 193
 Ulcers of leg (Sequeira), 411
 " of palm (Sequeira), 171
 Ulcus cruris, calomel in treatment of (abstr.), 387
 Urticaria bullosa (Little), 103
 " experimental study of pathogenesis of (abstr.), 335
 " papulosa (Little), 144, 176
 " pigmentosa (Little), 103, (Galloway) 130, (Eddowes) 296.
 " " nodularis (Little), 254
 Urticarial skin affections (abstr.), 264
- Vaccination, bullous dermatitis from (abstr.), 335
 Vaccinia of female genitals (abstr.), 388
 Varioliform eruption (Abraham), 142
 Vermin, superficial dermatosis due to (abstr.), 79
 Verrucæ planæ juveniles (Watson), 178
 Verruga Peruana, pathological anatomy of (abstr.), 157
 V. Recklinghausen's disease (Dore), 408
- White-spot disease (abstr.), 381
 Wounds, syphilis and (abstr.), 159
- X-ray dermatoses (abstr.), 196
 " ulcer becoming epitheliomatous (abstr.), 309
 X-rays, atrophy of skin from (abstr.), 222
 " in malignant growths (abstr.), 192
 " in Mycosis fungoides (Jamieson) 1, (Stainer) 212
 " in ringworm (Whitfield), 67
 " in therapeutics and diagnosis (Pusey and Caldwell), review of, 424
 " pathological action of (MacLeod), 365
 " rodent ulcer treated by (Little), 96
 " sclerodermia (Stainer), 36
 Xanthelasma, electrolytic treatment of (abstr.), 195
 Xanthoma, a certain form of (abstr.), 424
 " diabeticorum (Abraham), 456
 " tuberosum multiplex (abstr.), 386

INDEX OF NAMES

OF ORIGINAL CONTRIBUTORS AND EXHIBITORS OF CASES.

-
- | | |
|--|---|
| Abraham, P. S., 141, 215, 295, 456 | Meachen, N., 104, 176, 216, 459 |
| Adamson, H. G., 287, 447 | Morris, M., 410 |
| Baumann, E. P., 288 | Ogilvie, G., 11 |
| Crocker, H. Radcliffe-, 65, 98, 292 | Ormerod, J. A., 26, 289 |
| Dore, S. E., 169, 323, 407 | Pearson, V., 132 |
| Eddowes, A., 32, 102, 143, 172, 296 | Penrose, F. G., 134, 289 |
| Evans, W., 129, 250, 319, 408 | Pernet, G., 105, 146, 170, 255, 459 |
| Ewart, W., 63 | Pringle, J. J., 28, 41, 98, 134, 211, 290 |
| Fox, T. Colcott, 130, 251 | Roberts, L., 313 |
| Freeman, W. T., 206 | Rutherford, H. V., 297, 461 |
| Galloway, J., 24, 81, 130, 207, 235, 252 | Savill, T. D., 106, 145, 177, 461 |
| Hall, A., 311, 403 | Sequeira, J. H., 100, 121, 135, 171, 211, 411, 455 |
| Hartigan, T. J. P., 104, 174 | Shillitoe, A., 34, 100, 107, 136, 146, 177, 217, 298, 412, 456, 461 |
| Huie, L., 391 | Skinner, H., 125 |
| Jamieson, A., 1, 391 | Stainer, H., 34, 137, 212 |
| Little, G., 25, 34, 95, 103, 144, 169, 175, 209, 252, 297, 408, 452, 457 | Stowers, J. H., 47, 213, 462 |
| MacLeod, J. M. H., 25, 65, 81, 131, 132, 147, 197, 262, 365, 453 | Warde, W., 37, 108, 161, 178, 218, 277, 298, 349, 462 |
| Maguire, G. J., 428 | Watson, C., 178 |
| | Weber, P., 138 |
| | White, P., 21 |
| | Whitfield, A., 66, 101, 138, 214, 218, 273, 294, 413, 456 |

